THE INTERPERSONAL DYNAMICS OF TREATMENT OF ALCOHOL ABUSE

BY

JAMES CRAIG ANSEL

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This dissertation is dedicated to the spirit of goodwill and social service. The author is fortunate to have received patient care and indulgence in his formative years and to have the opportunity now to return a similar investment to others. The intention behind this project is to foster a career that serves more to benefit mankind than the material interests of a single individual.

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James Craig Ansel

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Chairman: Harry Grater, Ph.D.
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This research examines the interpersonal dynamics of the interaction between treatment personnel and alcohol abusers in individual treatment. The dynamic development of the relationships between alcohol clients and therapists is analyzed in terms of the effect on treatment outcome.

Literature is reviewed from five content areas: (1) personality characteristics of alcoholics, (2) attitudes of treatment personnel, (3) patient-therapist matching and consequent implications for psychotherapeutic interventions, especially in regard to (1), (4) psychological treatment of alcoholism, and (5) assessment of outcome of alcoholism treatment.

The interpersonal dynamics of therapist-client dyads engaging in individual treatment of alcohol abuse at the Northern Nebraska Comprehensive Mental Health Complex and the Sunset Mental Health Center in Brooklyn were assessed via ratings of audiotaped excerpts of therapy

sessions on the Leary Interpersonal Check List. Interpersonal complementarity was assessed according to the Behavioral Analysis System.

Treatment outcome was addressed from client changes in pattern and extent of alcohol consumption and from client changes in general adjustment. Client changes in alcohol consumption were assessed via client self-report of drinking behavior on pre- and post-treatment scores on the Khavari Alcohol Test and via ratings by therapists on the Rogers and Dymond Outcome Evaluation Form. Client changes in general adjustment were assessed via client self-report of adjustment on pre- and post-treatment scores on the Current Adjustment Rating Scale and via ratings by therapists on the Rogers and Dymond scale.

General findings are as follows: (1) alcohol abusers and counselors tend to behave in rigid and complementary ways in initial treatment interactions, (2) higher rates of interpersonal complementarity in initial sessions were associated with an increase in length of treatment, (3) counselors did not tend to alter their initially rigid interpersonal presentation as treatment progressed, (4) client interpersonal flexibility showed only a weak relationship to improvement in general adjustment, (5) counselor interpersonal behavior during sessions was not associated with a significant effect on treatment outcome, (6) higher rates of interpersonal complementarity were associated with clients' improvement in drinking behavior, (7) clients' improvement in drinking behavior was associated with clients' improvement in general adjustment, and (8) the length of treatment was associated with all measures of treatment outcome.

CHAPTER 1

INTRODUCTION AND STATEMENT OF THE PROBLEM

The purpose of this research is to examine the interpersonal dynamics of the treatment of alcohol abuse. The effect of the relationship between the alcohol abuser and the alcohol counselor in individual psychotherapy on treatment outcome is the fundamental issue to be addressed in this thesis. In particular, the complex reciprocal nature of the treatment relationship is defined and analyzed.

It is important to note at the outset that the effectiveness of alcoholism treatment in general remains an issue. In a review of 285 evaluation studies of psychologically oriented alcoholism treatment, Emrick (1975) reported a two-thirds improvement rate. Armor, Polich, and Stambul (1978), in another review of evaluation studies, reported that rates of treatment success range from 30 to 75 percent. Taking methodological problems into account, and considering rates of improvement without treatment, empirical support for the efficacy of alcoholism treatment in general is not conclusive. According to Armor et al., empirical support for the effectiveness of traditional individual psychotherapy with alcoholics is even weaker than the support for the effectiveness of alcohol treatment in general.

Many authors have addressed the interpersonal interaction between alcohol abusers in treatment and counselors as a fundamental issue in understanding alcohol treatment. In their book evaluating the state

of the art of alcohol treatment, Pattison, Sobell, and Sobell (1977) argue that the effects of any treatment are largely determined by interpersonal relationships. One recommendation offered by these authors is that certain kinds of individuals should be strategically assigned to particular therapeutic roles. Further, the "life health" issues associated with alcohol abuse can be conceptualized as interpersonal in nature. Intervention into the "family and personal disequilibrium ... may allow the alcoholic to re-equilibrate with different defenses and relationships which eliminate the personal and social forces that perpetuated the addictive pattern of drinking" (p. 276).

In similar fashion, Pattison (1966), and Sowa and Cutter (1974) contend that the 'quality" of the therapist-client relationship is a critical factor in treatment outcome, particularly in light of keeping alcoholics in treatment.

This notion that patients' continuation in treatment is essential to positive outcome and that length of treatment is a valid indicator of treatment success is prominent in the literature. Patient 'dropout" has long been regarded as a key problem in alcohol rehabilitation. Further, "erratic'/unstable treatment contact in which clients do not receive regular and continuing therapy has been recognized as a pattern in alcoholics (Armor et al., 1978).

The emphasis on the interpersonal dynamics of treatment becomes increasingly critical when considered in light of the broad range of problems of the alcohol abuser. Pattison, Sobell, and Sobell suggest that treatment goals should address all areas of alcohol-related life

and health problems. These authors contend that the focus on the abstinence criterion in general and drinking in particular has resulted in a distortion of outcome evaluation and has prevented the field of alcoholism treatment from achieving a finer understanding of successful treatment.

This thesis conceptualizes alcohol abuse as an interpersonal problem. This formulation is not intended to imply that this is the only way to understand alcohol abuse, however, when considering the range of psychosocial problems associated with abusive drinking and the interpersonal behaviors and situations which reinforce and perpetuate alcoholic behavior, it becomes readily apparent that an appreciation for the multipersonal network that characterizes alcohol abuse is imperative in understanding treatment. In this thesis treatment is defined as a strategic shift in the predominant interpersonal style of the alcohol abuser which contributes to all of the life problems associated with abusive drinking.

CHAPTER II

REVIEW OF THE LITERATURE

In this section of this thesis, literature from psychotherapy in general and from alcoholism treatment in particular is considered and conclusions and hypotheses are generated concerning the dynamic interaction between alcohol treatment personnel and alcohol abusers in treatment and the effects of this interaction on treatment outcome. Issues surrounding assessment of treatment outcome are also discussed.

Personality Characteristics of Alcoholics and Implications for Interpersonal Dynamics

Personality variables have been considered as having significant input into the behavioral syndrome associated with alcohol abuse. As recognized by Sterne and Pittman (1965), Pattison et al. (1977), and Armor et al. (1978), the personality characteristics of alcoholics have frequently been recognized as a serious impediment to treatment success in an absolute sense (i.e., that these people are simply difficult to treat). Nevertheless, this contention has not been adequately demonstrated. More primary to this discussion, however, is the issue involving the existence of personality characteristics that alcohol abusers have in common.

The resolution of this issue is critical enough to merit the volumes of theory and research dedicated to the existence or non-existence of the

'alcoholic personality." The fields of treatment and prevention of alcohol abuse could emphasize particular kinds of interventions designed for distinct personality characteristics and directed toward a more limited spectrum of personal and interpersonal issues.

The issue surrounding the existence of the "alcoholic personality" may have been regarded as resolved twenty-five years ago as two independent reviews of the available literature attempting to differentiate the personality traits of alcoholics from those of non-alcoholics concluded that there was no empirical justification for postulating an alcoholic personality. Both Sutherland, Schroeder, and Tordella (1950) and Syme (1957) concluded that they had found no satisfactory evidence to support the conclusion that persons of one personality type are more likely to become alcoholics than persons of other personality types. Syme's final comment is that, based on "all available relevant literature published from 1936 to 1956" (p. 301), the empirical justification for postulating the "alcoholic personality" is insufficient because of methodological inadequacies in the case of projective tests and because of theoretical weakness or lack of "meaningfulness" in the case of nonprojective tests.

Since these reviews, however, a fairly clear picture of personality characteristics that alcohol abusers have in common has emerged. Support for the notion that particular personality configuration are associated with alcohol abuse has come from three major areas: longitudinal research comparing preaddiction personality assessments with assessments made after onset of addiction, consistent patterns found in MMPI profiles for all groups of alcoholics, and literature on socio-psychological and sociological aspects of alcoholism and treatment of alcohol

abuse. This research supports the contention that alcoholics tend to present a facade of strength under which a conflict over dependency is hidden. Dependency needs are not addressed directly leading to hostility and resentment, particularly toward individuals in authority. Consequently, alcoholics tend to be overtly antisocial and rebellious, leading to difficulty establishing intimate relationships.

Since 1960, four longitudinal studies examining personality characteristics before and after onset of problem drinking have emerged. Jones (1968) used a longitudinal sample from the Oakland Growth Study to examine the personality characteristics of individuals who later became problem drinkers versus individuals who did not become problem drinkers and concluded that behavior associated with problem drinking is to some extent an expression of personality tendencies established long before problem drinking begins. The California Q set was administered and compared for three age periods: junior high school, senior high school, and adulthood. Throughout all three assessments problem drinkers were distinguished by a set of traits suggesting underlying dependence with over-compensatory strivings for "masculinity" causing them to be rebellious, impulsive, and undercontrolled. Moderate and abstinent drinkers were less hostile and more capable of dependency in an intimate relationship, particularly early in life.

In a thirty-year follow-up of adults who had been seen as patients in a child guidance clinic in St. Louis, Robins (1966) and Robins, Bates, and O'Neil (1962) compared agency records on a standard questionnaire with measures on the same questionnaire on the same sample of

individuals in adulthood. The authors reported a powerful antecedent factor evident in the childhood histories of clinic patients related to problem drinking later in life was the occurrence of a variety of symptoms of antisocial behavior.

McCord and McCord (1960, 1962) examined data gathered from alcoholic fathers of subjects in a lower-class population in Boston to determine differences between boys who later grew up to be alcoholics versus boys who grew up to be "non-deviants." Compared with non-deviants, prealcoholics were more self-confident, undisturbed by normal fears, indifferent or disapproving of family members, more actively aggressive, and emphasized their independence. The interpretation offered by the McCords is that the prealcoholic presents a facade of "masculinity" which is manifested by a denial of dependency needs and that drinking becomes a means by which the alcoholic can satisfy dependency needs and still maintain a masculine self-image. These authors found a similar personality pattern in adult alcoholics with more overt expressions of dependency as their condition deteriorated.

Two reviews of the longitudinal research cited above have concluded that a clear and consistent picture of the predominant personality characteristics of alcohol abusers and prealcoholics is supported. Senford (1968), in considering the findings from all these studies, concludes that "it seems reasonably clear that at least in some male problem drinkers an underlying dependence with overcompensatory strivings for 'maleness' is an important predisposing factor" (p. 15). In a comparison of Jones' and the McCords' research, Lisensky-Gomberg (1968) is less reserved in her conclusion:

> There are not only differences in methodology and data-gathering instruments in the two studies, but there is also an unambiguous difference in the class status of the research subjects. What the two longitudinal studies have done is to point some of the behaviors which distinguish the prealcoholic person from others of similar background. They have begun to define psychological predisposition with some specificity. (pp. 18-19)

A fourth longitudinal study of personality traits of alcohol abusers is part of an extensive body of MMPI data supporting the picture of the alcoholic stated above. Kammeier, Hoffman, and Loper (1973) compared college-entrance MMPI profiles with the same men entering treatment for alcohol abuse and found that both sets of profiles showed elevated scores on the following scales: Pd (Psychopathic deviate), D (Depression), Ma (Hypomania), and Sc (Schizophrenia). The authors concluded that these elevations may be indicators of dependency problems and further suggested that "this combination of elevated scales may represent a neurotic pattern of a self-centered, immature, dependent, resentful, irresponsible kind of person who has been unable to face reality" (p. 396). Kammeier et al. also referred to the internal distress suffered by alcoholics who attempt to maintain a facade of strength in spite of such distress.

This "classic Pd-D" MMPI profile in alcoholics found by Kammeier et al. has consistently been found in other research evaluations of MMPI scores of alcohol abusers (Goss and Morosko, 1969, Lenyon, 1968, MacAndrew and Geertsma, 1963, Hill, Haertzen, and Davis, 1962; Dahlstrom and Welsh, 1960, Rosen, 1960; Hoyt and Sedlacek, 1958). This body of research is based on a broad range of populations of alcohol abusers spanning Skid Row types to hospitalized inpatients to outpatients and including young, old, single, married, male, and female

subjects. Briefly stated, the personality correlates that have been associated with problem drinking within this MMPI research are dependency conflicts, antisocial behavior, remorseful intrapunitiveness, passive-aggressive styles, depression, neuroticism, internal hostile impulses, problems with authority, and rebelliousness.

This picture of the personality correlates of problem drinking is also supported by a variety of socio-psychological and sociological analyses of alcohol abuse. These analyses are consonant with the view taken by Pattison et al., 1977:

> Alcoholism may be best described as a psychosocial behavior syndrome which is dependent on a variety of social and cultural variables. Changes in patterns of drinking behavior may result not so much from changes in personality variables as from changes in social and cultural variables. (p. 161)

In a sociological analysis comparing rates of drinking and drunkenness with indicators of indulgence of dependency in infancy and childhood and with the acceptance of dependent behavior in adulthood in 110 societies, Bacon (1974) found results that supported "the dependency-conflict hypothesis that frequency of drunkenness is related to customs that limit the indulgence of dependence in infancy, emphasize demands for achievement in childhood and limit dependent behavior in adulthood" (p. 363). Bacon offered the explanation that when the customs of a society created these conditions, a psychological state of conflict associated with help-seeking behavior would be expected to develop. Since the satisfaction of dependence was prohibited, drinking is one available method by which an individual could resolve this conflict by simultaneously satisfying his/her dependency needs and avoiding the anxiety associated with overt expression of dependency in a sober state.

The dependency conflict in alcoholics has been a theme in the literature in treatment of alcohol abuse. Armor et al. (1978) have concluded that overtly dependent alcoholics are more amenable to treatment than counterdependent types, particularly in light of likelihood of continuing in treatment. One implication of this conclusion is that the more conflicted an alcohol abuser is about dependency, the less likely it is that he/she will be able to establish a stable and meaningful contact with treatment personnel.

Pattison et al. (1977) have offered a psychoanalytic formulation of the dependency issues in alcoholics. Although their conclusions are highly speculative, they are interesting to consider. These authors suggest that problem drinking may represent the oral phase of psychosexual development and that a differential diagnosis should be made between the alcohol abuser who has regressed to an oral level of development from a previously more mature level and an orally fixated alcoholic. The prognosis for a return to normal drinking and successful psychotherapy is higher in the regressed patient while the fixated patient is expected to continue addictive drinking.

Both Forrest (1978), in his work on diagnosis and treatment of alcoholism at the Institute of Addictive Behavioral Change, and Brown and Yalom (1977), in their work describing techniques and problems encountered in group treatment of alcoholism, address the difficulty that alcoholics have expressing their dependency needs. These authors concur with Bacon in suggesting that drinking is a covert way of satisfying dependency needs without recognizing them. These clinical descriptions recognize two styles of expressing the dependency conflict

overt dependency and overt counterdependency. Both styles are associated with guilt and hostility, and both lead to problems with authority and with intimacy.

In similar fashion to Forrest (1978), to Armor et al. (1978), and to Brown and Yalom (1977), Baekland and Landwall (1975) discuss dependency and counterdependency in alcoholics and how counterdependency can lead to dropping out of treatment. They contend that addressing the dependency conflict is the key issue in keeping an alcoholic in treatment, and, consequently, the key issue in treatment success. In a sense, these authors are implying that a critical component in the therapeutic relationship is the therapist's ability to satisfy the dependency needs of the problem drinker.

A number of studies have addressed the interpersonal dynamics of alcohol abuse more directly. Hurwitz and Lelos (1988) defined alcoholism as a 'sociopsychological problem manifested largely by, as well as reflecting, difficulties in interpersonal relations' (p 65). Interpersonal behavior in non-help-seeking alcoholic employees (i.e., employees who came to treatment in order to keep their jobs and would not have attended treatment otherwise) was assessed via the Leary Interpersonal Multilevel Personality Model (Leary, 1957). The authors offer conclusions that are highly consonant with the other authors reviewed in this thesis.

> The interpersonal and intrapersonal profiles reveal considerable conflict and suggest the presence of a high degree of resulting psychological strain. They present the same outward facade of bland hypernormality found by several prior investigations among different categories of alcoholics. Beneath this facade however, strong dependency wishes, or hostility, or a combination of both prevail among a majority of the sample. Due apparently to the cultural demands for adult male independence and autonomy, however, these dependency strivings are generally

> both consciously rejected and denied overt public expression. The underlying hostility, moreover, is represented in over half the cases.
>
> While the defensive facade manifests itself largely in overt behavior and conscious self-description it is basically not a conscious deliberate coping mechanism. It appears, rather, to be an unconscious attempt to cover up and compensate for underlying feelings of dependency or hostility. What these men consciously experience is probably a pervasive feeling of high tension due to other unresolved conflicts. (p. 70)
>
> For all the alcoholics--the overtly dependent, the counter-dependent and the latently hostile men--excessive drinking apparently serves several concurrent and crucial psychosocial functions. It resolves their severe dependency by allowing them to maintain a conscious public interpersonal and self-image of masculine adequacy based on their ability to "drink like a man" while at the same time satisfying, in their drunken states, strong dependency yearnings. Furthermore, it provokes an outlet in their drunken rages for repressed hostile impulses. (Hurwitz and Lalos, 1968, p. 71)

Given the particular personality traits that alcohol abusers tend to have, it is possible to speculate as to the kinds of interpersonal relationships in which alcohol abusers would tend to become involved. Pattison et al. (1977) have discussed this notion in light of two traditional models of psycho-social interaction. First, these authors use transactional analysis (Berne, 1964) to present the "multiperson network that characterizes alcoholism' (p. 156). A number of people in the interpersonal network of the alcoholic "game" are viewed as perpetuating alcoholic behavior, and, more germane to the thesis presented in this paper, psychological cure of the alcoholic requires that he/she

stop playing the game entirely. Second, Pattison et al. use an analysis of the social gestalt of the interaction between the alcoholic and "significant others" (including members of the alcoholic's nuclear family) to support the contention that "patterns of drinking are less a reflection of individual pathology than of psychosocial gestalt" (p. 158) and that the change from abusive drinking to normal drinking requires a shift in "psychosocial equilibrium."

Leary (1957), Carson (1969), Benjamin (1974), and McLemore and Benjamin (1979) provide theoretical models based on Sullivan's Interpersonal Psychiatry (1965) that examine interactional patterns in human relationships. These models emphasize the principle of interpersonal reciprocity which maintains that interpersonal behavior should be examined in light of the particular behavior of the individual in question, that individual's perceptions and expectations of others, and the responses that that individual elicits from others. Thus, the most prolific unit of analysis is the self-other interaction, and, more specifically, the reflex way in which human beings interact with each other. According to these theories and as much as alcohol abusers tend to present predominant types of behaviors, problem drinkers tend to pull certain reactions from others, and thus, tend to have particular kinds of interactions with others.

Leary labels the individual with personality correlates like those that alcohol abusers tend to have the 'distrustful personality.' Although these individuals may consciously strive for intimacy, they consistently avoid such relationships. They tend to demonstrate distrust and rebellion as solutions to personal dilemmas and are usually frustrated, depressed, resentful, and dissatisfied. They tend to be

unable to maintain durable relationships based on conformity and collaboration. The kinds of reactions they tend to provoke from others are characterized by rejection and punishment. Within the analysis provided by Leary, the personalities of those individuals are hostile and submissive, and they tend to elicit hostility and dominance in others. The rebellious and distrustful person tends to create relationships in which he/she is treated with punitive rejection.

The implications of these models of interpersonal complementarity are supported by research examining the personality characteristics of wives of alcoholics and the kinds of interpersonal behaviors that spouses of alcohol abusers tend to exhibit. Hurwitz and Daya (1977) used the Leary Interpersonal Multilevel Personality Model to study the interpersonal behaviors of the wives of the alcoholics used in the research by Hurwitz and Lelos cited earlier in this paper. The results were consonant with the hypotheses generated by the theories of interpersonal reciprocity offered by Leary (1957), Carson (1969), and Benjamin (1974). They found that wives of alcoholics tended to demonstrate dominance in their interpersonal behavior. Further, these wives tended to yearn for a dependent interpersonal role in their marriage but consciously reject these feelings as they are unable to express them overtly. These findings suggest that the dependency conflict within alcohol abusers also tends to occur in relationships involving alcohol abusers.

Other research on marriages with an alcoholic partner supports the analysis presented above. Lemert (1962) defined dominance and dependency sociologically and found that wife dominance in a sample of alcoholism families was twice as high as wife dominance in a sample of separation families and three times as high as wife dominance in a

control sample. In describing the wife-alcoholic interaction, Sands, Hanson, and Sheldon (1967) characterized the wife as the punitive and controlling mother and the alcoholic as the rebellious child. Rae and Drewery (1972) administered the Interpersonal Perception Technique and the MMPI to alcoholics and their wives and to a control sample. They found more confusion of socio-sexual roles and dependence-independence needs in the alcoholics' marriages. They also found that control wives scored lower on dominance and autonomy and higher on deference, affection, succorance, abasement, and nurturance than wives of alcoholics. In addition to this evidence, both Bailey (1970) and Bullock and Mudd (1959) conclude that alcoholic marriages tend to be characterized by a high degree of conflict between marriage partners.

This analysis of the kinds of interpersonal relationships that alcohol abusers tend to have in general has powerful implications for the kinds of relationships that problem drinkers would tend to have with treatment personnel. As with their interactions with their spouses, alcoholics may tend to elicit punitive rejection from therapists and counselors. According to the theories of interpersonal reciprocity, alcohol treatment personnel would experience similar kinds of conflict and resentment and behave in a covertly hostile and overtly dominant fashion toward alcohol abusers in treatment. This notion is examined below.

Attitudes of Alcohol Treatment Personnel

The attitudes held by treatment personnel toward alcohol abusers have been a matter of great concern in the field of alcoholism treatment. Most evaluations have characterized these attitudes as pessimistic

and conflicted. The detrimental effects of these attitudes on diagnosis and referral (Hanna, 1978, Cantor, 1977) and on treatment (Ferneau and Paine, 1972, MacDonald and Patel, 1975, Chappel and Schnoll, 1977, Rathod, 1967) have been presented and discussed. In this section of the thesis, the literature on the attitudes of treatment personnel is reviewed and a general interpretation is offered.

One clear and consistent finding that is well documented in evaluations of alcohol counselors' attitudes is that the attitudes held by treatment personnel toward alcoholics and alcoholism treatment are negative (Sowa and Cutter, 1974, Knox, 1971, Fisher, Keeley, Mason, and Fisher, 1975, Hanna, 1978, Robinson and Podnos, 1966, Harlow and Goby, 1980, Mendelson, Wexler, Kubsansky, Harrison, Leiderman, and Solomon, 1964). More specifically, Knox (1976, 1974, 1969) and Sterne and Pittman (1965) reported a general pessimism regarding alcoholics' ability to respond to treatment.

An equally consistent finding that is perhaps more critical to this discussion is the inconsistency in attitudes held by treatment personnel. Sterne and Pittman's (1965) respondents rated the alcoholic's role performance in treatment negatively on the same behaviors that they specified as criteria for determining motivation for treatment. These authors labelled this inclination a "self-reinforcing tendency" and inferred that the respondents were not considering the possibility of enhancing the alcoholic's motivation for rehabilitation. Some of Sterne and Pittman's respondents explicitly indicated that it was not their position to do so. Mackey (1969) found that caregiving and mental health professionals held consistent views of "normal" individuals but did not agree in their perceptions

of the "alcoholic." In examining the attitudes of psychiatric residents, Farneau and Gertler (1971) found a conflicted and ambivalent view of alcoholism. On one hand, the residents held a positive and essentially therapeutic stance. On the other, a significant counter-attitude that alcoholism was a fault that resided within the individual was evident. Berger-Gross and Lisman (1979) reported that paraprofessionals working in a residential alcoholism treatment facility were more lenient and 'humanistic' as well as more "custodial" in their attitudes toward alcoholics than paraprofessionals working in a detoxification center.

Knox (1971) concluded that "psychologists and psychiatrists have many opinions in common and share a marked inconsistancy in their attitudes toward alcoholism" (p. 1677) in research examining the attitudes of psychologists and psychiatrists. Knox's findings were that, although treatment professionals reject the court system as the appropriate institution for referral and treatment and favor hospital treatment over referral to the court system, they saw the benefit to be gained by hospital care as minimal and the general prognosis for alcoholics as poor. Some of the respondents recognized the inconsistency in their attitudes. Further, Knox's respondents were generally unwilling to devote their personal time and energy to treating alcoholics.

Sterne and Pittman have redefined the tendency for treatment personnel to emphasize the importance of motivation for treatment success (Knox, 1971; Sterne and Pittman, 1965) as a product and correlate of the inconsistancy in attitudes toward alcoholics. These authors suggest that the emphasis on motivation is part of a professional

defense system which is based on the creation of a comfortable personal distance between treatment personnel and the problem drinker. The respondents in the research by Sterne and Pittman described alcoholics as making "unreasonable demands for attention' and as "inconsiderate of others'. The following issue is raised by the authors:

> It might be asked whether the recurrent posing of the motivational problem is not a convenient rationale for an unwillingness to assist the alcoholic patient or client more effectively, especially since admission under a primary diagnosis of alcoholism is not permitted by 40% of thirty-five surveyed hospitals, medical treatment is usually limited to brief detoxification with infrequent follow-up or referral, and only two-fifths of the fifty-nine surveyed agencies actually work with alcoholics and then with the frequent goal of referral elsewhere for the alcoholism. (p. 54)

Numerous authors have recognized the distancing of the alcoholic by treatment personnel. In addition to finding that few psychologists and psychiatrists are willing to devote a significant portion of their time to treatment of alcoholics, Knox (1976) referred to the 'referral game" in which the alcohol abuser "is sent from one professional to another with little therapeutic interaction along the way' (p. 162). Knox (1971) found that psychiatrists and social workers tended to support referral of alcoholics to hospitals and psychologists tended to support referral to Alcoholics Anonymous. Further, Knox (1976) found that psychologists were willing to devote more time to treatment of drug abuse than to treatment of alcoholism and that the respondents perceived cultural pressures as the primary cause of drug abuse whereas intrapersonal conflicts were seen as the primary cause of alcoholism. Schulberg (1966) found that 23% of the surveyed psychiatrists in private practice would not accept alcoholics for treatment. Bailey (1970) found that 60% of the surveyed treatment personnel believed

that treatment should be provided in specialized alcoholism clinics--not in agencies like their own. In addition, Bailey reviewed the perceived demands made by alcoholics in treatment and the perception of treatment personnel that the alcoholic is more difficult to relate to than an individual whose illness is not self-inflicted. In light of this conception of a created and comfortable distance between the alcohol abuser and the treatment professional.

The negative and conflicted attitudes held by treatment personnel toward alcohol abuse and alcoholism treatment have been repeatedly discussed in light of the potential detrimental effects on treatment. Mogar, Halm, Snadaker, Snedekar, and Wilson (1969) have suggested that, 'in addition to expressed attitudes, unconscious reactions by staff members to acting-out forms of disturbance may actually encourage the deviant behavior or force its suppression. In either case, the result is antitherapeutic" (p. 449). Both Mogar et al. and Rainahr (1968) have provided evidence for the negative effect of incongruent attitudes between patients and therapists on communication and treatment outcome.

An alternative interpretation of the relationship between the attitudes of treatment personnel and treatment effectiveness, however, has been proposed. Trice and Balasco (1968) found that training acted to lower supervisors' tolerance of alcoholic employees but increased their willingness to engage in realistic confrontation and referral--that attitude change in a negative direction led to positive action. The authors offered this interpretation:

> There is no doubt that many current training and educational efforts are unsuccessful because they miss the mark.

> concentrating on the illness aspect of alcoholism, for example, may result in an increased acceptance and tolerance of the alcoholic by the supervisor. Lowering the toleration by 'significant others' in the alcoholic's work would simultaneously raise the "bottom" for the alcoholic, promising earlier referral and treatment. (p. 396)

Kilty and Feld (1979) presented a similar conclusion based on the same findings:

> These results suggest that less tolerance and acceptance of alcoholics may enhance intervention. Perhaps the well-documented findings that experience in working with alcoholics and participating in training programs lead to more negative attitudes may have been misinterpreted as to the effect of this change in treatment and rehabilitation. (p. 930)

The negative effect of the societal trend to regard alcoholics as less personally responsible for their illness was recognized by Orcutt (1976) who suggested that the medical model may lock the alcoholic into a "non-responsible, but stigmatized deviant type." The half-acceptance of the sick role of the alcohol abuser may indeed be less effective as a treatment posture than a less tolerant but clearer position.

The effects of experience in treatment and training on attitudes held by treatment personnel as referred to by Trice and Belasco have been investigated by a number of authors. Both Sterne and Pittman (1965) and Magar et al. (1969) found that increased experience in treatment was associated with a more optimistic, disease-oriented view of alcoholism with fewer moralistic judgments being made. Hanna (1978) and Chafetz (1961) also concluded that contact with alcoholic patients led treatment personnel to treat alcohol abusers with more regard.

Other researchers, however, did not find this positive effect of experience on attitudes. Mackey (1969) reported that age, years in line of work, and formal education showed no particular effect

on attitudes. Sowa and Cutter (1974) found that staff who were involved in direct service contact with alcohol abusers held less favorable attitudes than staff who were not involved in direct service contact. Negative effects of experience were also reported by Knox (1971), who found that trainees were more willing to work with alcoholics than staff were, and by Ferneau and Gertler (1971), who concluded that the first year of psychiatric residency increased the conflict in regard to alcoholism.

The findings regarding the effect of formal training on attitudes held by treatment personnel are conflicting in a similar fashion to the findings regarding the effect of experience. A number of investigations (e.g., Fisher, Fisher, and Mason, 1976, Chappel, Jordan, Treadway, and Miller, 1977, Gideon, Littell, and Martin, 1980) have reported positive changes in attitudes following training, however, a number of formal evaluations of training programs (Cooke, Wehmer, and Gruber, 1975, Waring, 1975, Kilty and Feld, 1979, Rosenberg, Gerrein, Manohar, and Liftik, 1976) found no changes in attitudes following training. Knox (1976) and Levitt, Raganz, and Blachly (1963) concluded that, in general, formal training results in a change in informational knowledge in the trainee but shows no effect in altering attitudes in a desired direction.

Other studies have provided evidence that training results in an increase in negative and conflicted attitudes (Ferneau and Gertler,

1971, Trice and Belasco, 1968). Bailey (1970) concluded that training leads to greater discomfort in the trainees because of the emotional impact of the training content

> For the first time, cultural and professional stereotypes about alcoholism were confronted and threatened, and the course participants were asked to learn, to think, and even to feel in new ways. It is probable that most of them had never had such a concentrated exposure to alcoholism material, nor had their deeply ingrained stereotypes been held up to critical self-examination. (p. 682)

Differences in populations, content of training programs, and mode of assessment of attitudes make the findings concerning the effects of training and experience on attitudes difficult to consolidate. One implication of these findings is that training and experience may make treatment personnel more accepting and tolerant of alcoholics and alcoholism in terms of their sophistication and knowledge, however, increased contact with alcohol abusers may enhance "negative" emotional reactions in treatment personnel.

This research has implications for training of treatment personnel as recognized by Knox (1976), Bailey (1970), Ward and Wallace (1970), Reinahr (1969), and Mendelson et al. (1964). These authors have suggested that the attitudes of trainees should be addressed from two directions. The first is an educational approach to counteract judgmental attitudes arising from cultural stereotypes. The second, and more critical direction, is preventative and experiential in nature and designed to prepare trainees for the emotional reaction to working with problem drinkers. Further, these authors have suggested that ongoing in-service training may assist in mitigating professional avoidance and attitudinal blocks.

In addition, these findings have implications for the development of new and innovative treatment strategies as recognized by Knox (1971). Sterne and Pittman (1965) also allude to the development of new approaches:

> Again, motivation for sobriety is often implicitly equated with conformity to the specifications of treatment set by the therapist, such as willingness to keep regular appointments, to undergo a specific form of treatment, for instance psychotherapy, or to see alcoholism as a symptom of an underlying psychiatric condition rather than as a ramifying problem to be addressed directly. Yet research has not shown that any of these are prerequisite to sobriety. (p. 54)

Ward and Faillace (1970) utilized general systems theory (Von Bertalanffy, 1968) as a theoretical model to integrate the research findings on the attitudes held by treatment personnel toward alcohol abusers. This conceptual framework maintains that the behavior of a particular element in a system is highly dependent on the complex processes within the total system. In their analysis of the treatment situation, Ward and Faillace focused on the continuous feedback between components of the system. They proposed that the relationships between alcoholics and treatment personnel can be "pathological complementary relationships" in which each participant's behavior influences the other's behavior.

In similar fashion, Reinehr (1965) has examined the negative effects of the label "alcoholic" on both the patient and the therapist. Sterne and Pittman (1965) and Bailey (1970) have also noted the interactive nature of the treatment situation. Sterne and Pittman suggested that:

> the responsibility for discontinuance in treatment need not necessarily be the alcoholic's. The therapeutic situation is an interactive one, and research has shown that therapists play a large part in determining the nature of the therapeutic relationship. (p. 54)

The systems approach to the research on attitudes held by treatment personnel proposes that the most prolific analysis of the treatment situation should focus neither on the alcohol abuser exclusively nor on the treatment staff exclusively, but on the complex interaction between the two.

This systems analysis can be extended beyond the treatment situation specifically to the treatment situation within a societal framework. Alcohol abusers and treatment personnel are elements in the same social matrix and, theoretically, are subject to the same social forces. Kilty (1975) found that treatment professionals tend to reflect the opinions and biases of the community within which they work. According to a systems formulation, it is not surprising that the attitudes of treatment personnel toward alcohol abuse are as conflicted and ambivalent as abusers' attitudes and as society's attitudes in general.

MacAndrew and Edgerton (1969), commenting on society's tolerance of intoxicated behavior, concluded that, "since societies, like individuals, get the sorts of drunken comportment they allow, they deserve what they get" (p. 15). The sociocultural factors influencing alcoholics and leading to their "resistance" to treatment may be the same factors influencing treatment personnel's "unwillingness" to invest in treatment. The ambivalence evident in abusers and treatment staff can also be seen in society's emphasis on treatment while maintaining the popular conception of the weak-willed and unmotivated alcoholic. Chafetz (1961) concluded that

> When the alcoholic fails to seek out treatment or fails to stay with it, the burden of failure should not be placed upon

him by labelling him a "hopeless alcoholic." Rather, the caretaking community should recognize its own failure to develop methods of establishing therapeutic relationships with these sick people. (p. 328)

An implication of this analysis is that treatment strategies should consider the complementary relationship between the alcohol abuser and treatment personnel, and interventions should focus on each participant's role in the interective system with special attention to expanding and modifying these roles.

In summary, a redefinition of the 'negative' and "conflicted" attitudes held by treatment personnel toward alcohol abuse and alcoholism treatment is proposed. Many of the authors cited above have contended that such attitudes are detrimental to treatment success. The interpretation proposed here is that these attitudes are complimentary reactions to the prepotent personality characteristics of alcohol abusers in treatment. To suggest that the "negative" treatment disposition of professionals is the issue at hand and that amelioration of such attitudes is the goal of treatment is a narrow and limited conception. The punitive and directive disposition of treatment personnel may be more accurately understood as the natural and appropriate reciprocal reaction for professionals to assume in the initial phases of some treatment relationships with alcoholics. Indeed, this is not to suggest that hostile punishment is the remedy to alcoholism. What is proposed here, rather, is that the research cited above portrays a realistic conception of the disposition of treatment personnel and that these personal reactions to alcoholics in treatment are fundamentally complementary.

In this thesis, the goal of treatment of alcohol abuse is to develop the initially rigidly defined treatment interaction toward a

more flexible and permissive equality. In order to develop this conception of the dynamic interaction of the therapist and the alcoholic in treatment, theory and research on patient-therapist relationships is examined below.

Patient-Therapist Matching: Implications for Treatment of Individuals with Hostile and Dependent Interpersonal Styles

Numerous theories have been proposed based on the notion that particular kinds of interpersonal dispositions are more effective therapeutic "matches" for certain complementary interpersonal dispositions in clientele (Sullivan, 1965; Leary, 1957; Carson, 1969; Shutz, 1958; Carkuff and Berensen, 1967; Millon, 1969; Benjamin, 1974). In reviews of literature on patient-therapist matching, Berzins (1977), Lubersky, Chandler, Averbach, Cohen, and Bachrach (1971), and Parloff, Waskow, and Wolfe (1978) have discussed research involving the following classes of matching variables--personal constructs, cognitive style, values, preferences, expectations, background characteristics, personality characteristics, and interpersonal style. The focus of the theories and research in this area is the systematic approach to isolating and understanding certain combinations of therapist and patient variables and their effect on treatment.

The definition of treatment in terms of the interpersonal dynamics of the relationship between therapists and clients is becoming increasingly influential in applied psychology. One of the products of this movement is the search for "therapeutic" and "psychonoxious" matches of patients and therapists and inquiries into the dynamic developing of the patient-therapist relationship. Strupp (1977) has concluded

that any analysis of the therapist's contribution to the process of psychotherapy is incomplete without including some conception of the relationship with the client. Analysis of therapist and/or client personalities qualities in isolation will provide incomplete and less meaningful information. Perloff et al (1978) offered this conclusion:

> We assume that as the interpersonal dimensions of therapy interactions are more carefully examined, it will become possible to define more clearly which kinds of persons help which kinds of clients most effectively. Such evidence will reduce the importance placed on creating techniques and will increase the emphasis on therapist selection and interpersonal skill development. (p. 180)

On the basis of Benjamin's (1974) Structural Analysis of Social Behavior, McLemore and Benjamin (1979) have pressed the issue further in proposing that psychology as a field should consolidate its knowledge in terms of interpersonal behavior. They argued for a psychosocial conception of psychiatric diagnostic schemata to replace traditional psychiatric nomenclature. The value of this effort would lie in the clinical and scientific advantages of an interpersonal taxonomy, particularly in diagnosis and treatment planning. The authors contended, on the basis of a review of available literature, that the DSM-III categories of dysfunction can be translated into particular categories of interpersonal behavior.

For the most part, the theories of interpersonal matching of patients and therapists have their roots in Sullivan's Interpersonal Psychiatry (Sullivan, 1965). He conceptualized 'personality' as an interpersonal product of the psychosocial history of an individual and, consequently, defined psychotherapy in terms of the dynamic interplay between client and therapist. Sullivan recognized the "complementary" and "antagonistic" nature of the tensions created

by particular matches of interpersonal needs in human relationships. His conception of emotional reciprocity was central to the theories of patient-therapist matching derived from Sullivan's theory. In any interpersonal situation, psychotherapy included, as each participant's needs are expressed, they are met by the other participant's needs, and these needs can be either aggravated or satisfied. In this sense, Sullivan identified the dyadic interaction as the fundamental unity of psychotherapy. In succession, Leary (1957), Carson (1969), and Benjamin (1974) operationalized and developed Sullivan's ideas (Berzins, 1977).

Leary and his colleagues at the Kaiser Foundation in Oakland developed a classification system known as the Interpersonal Circle (See Figure 1)--a circular arrangement of predominant interpersonal operations or "reflexes" built around two orthogonal axes (love-hate and dominance-submission). The circumplex was constructed by placing the two orthogonal dimensions perpendicular to each other creating four quadrants with each quadrant containing two octants--Managerial-Autocratic and Responsible-Hypernormal in the Dominance-Love quadrant, Cooperative-Conventional and Docile-Dependent in the Love-Submission quadrant, Self-effacing-Masochistic and Rebellious-Distrustful in the Hate-Submission quadrant, and Aggressive-Sadistic and Competitive-Narcissistic in the Hate-Dominance quadrant. Further, each octant is divided into two "reflexes." The circular arrangement is utilized so that the sector of the circle reveals what interpersonal operations are involved, and the distance from the center indicates how extreme

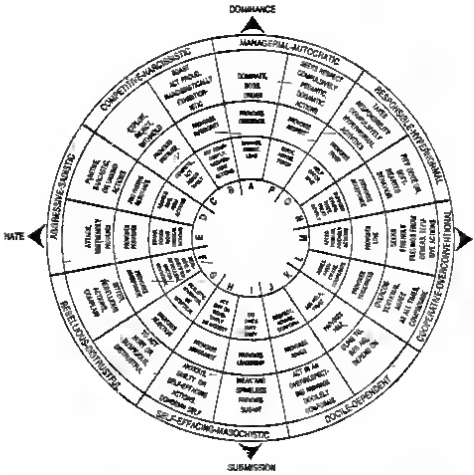


Figure 1. The Interpersonal Circle. From Berzins, J. I. Therapist-patient matching. In A. S. Gurman and A. M. Razin (Eds.), Effective Psychotherapy. A Handbook of Research. Oxford: Pergamon Press, 1977, p. 225

or intense they are. This circumplex, based on extensive clinical data, can be used to 'diagnose' an individual's predominant interpersonal style.

In regard to patient-therapist matching, individuals are presumed to reciprocate each other's effective disposition directly and to complement each other's stance on dominance-submission. That is, each individual's reflex pulls its complementary reflex from other individuals in dyadic intercourse (i.e., dominance provokes submission and vice versa, love elicits love, and hate elicits hate).

Carson (1969) developed a simplified version of the Interpersonal Circle to code social behaviors into the four quadrants in the Leary Circumplex. This arrangement was used to define four 'complementary" combinations in dyadic interactions (i.e., friendly dominance (F-D) and friendly submission (F-S) and vice versa and hostile dominance (H-D) and hostile submission (H-S) and vice versa). This analysis was the basis for Carson's discussion of psychotherapy. He contended that patients tend to maintain rigid interpersonal styles and that the purpose of the diagnostician was to ascertain the patient's style and supply a therapist with a complementary interpersonal style. Non-complementary therapists should be avoided because of the instability of the treatment relationship in such cases. The function of the therapist is to engage the patient in a complementary fashion initially but to avoid prolonged complementary reciprocation because it would result in a therapeutic relationship as rigid and inflexible as the patient's original interpersonal style. The therapist should be flexible in his/her interpersonal operations so that he/she can strategically "move" the patient around the Interpersonal Circle via

therapeutic maneuvers. This movement, according to Carson, is the therapy.

The most recent extension of Sullivan's ideas is Benjamin's Structural Analysis of Social Behavior (SASB). Benjamin (1974) used the same orthogonal dimensions defined by Leary to construct a more explicit and detailed structure based on behavioral opposites, complements, and antedotes (See Figure 2). The SASB structure was constructed on the basis of mathematical logic and extensive empirical analyses. It includes three diamond-shaped planes or surfaces. The top surface depicts interpersonal behaviors by their effect on the other person. The middle surface depicts behaviors initiated by the self. Opposite behaviors appear at 180 degrees from each other on the same plane so that, for example, the opposite of 115, "friendly listen" is 135, 'accuse, blame." Complementary behaviors, behaviors that tend to pull each other in social interchange, are at corresponding positions on the surfaces so that, for example, the complement of 235, "whine, defend, justify' is 135, 'accuse, blame." Antidotes are complements of opposites so that, for example, the antidote of 235, "whine, defend, justify' is 115, 'friendly listen." The bottom surface portrays when the behaviors on the top two surfaces are turned inward.

Although Benjamin's analysis is more automatic and detailed, she concurred with Carson in suggesting that complementary behaviors create stable relationships and that the purpose of therapy is to identify the patient's interpersonal style and supply of antidote in a strategic fashion.

The models of patient-therapist matching proposed by Benjamin, Carson, and Leary are supported by extensive empirical and clinical

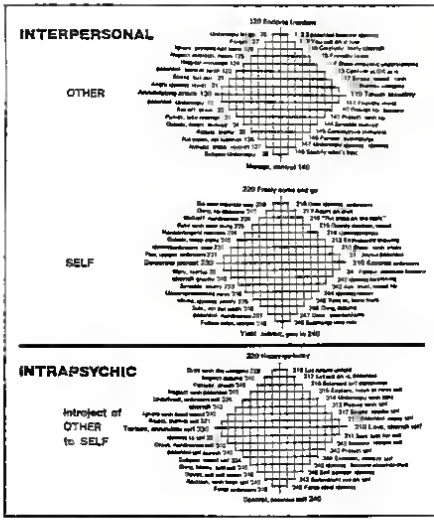


Figure 2. Benjamin's (1974) "Chart of social behavior." From McLemore, C.W. and Benjamin, L.S., Whatever happened to Interpersonal Diagnosis? A Psychosocial Alternative to DSM-III. American Psychologist, 1979, 34, p. 21.

data. Some of this support for their models is reviewed below (also see Berzins, 1977). Particular emphasis is placed on research involving dependency and hostility in clientele and 'complementary" behavior in treatment personnel.

One area of empirical studies that buttresses these theories of interpersonal reciprocity in treatment relationships is research finding therapist behavior to be a function of client behavior. Heller, Myers, and Kline (1963) trained actors to portray the patient roles in the four quadrants of the Interpersonal Circle (F-D, F-S, H-D, and H-S) in order to study interviewer behavior as a function of client input. Trained raters judged the interviewers' behavior on the Leary Interpersonal Check List (ICL), and the results were coincident with the models of interpersonal matching. Client dominance evoked passive interviewer behavior, and client dependence evoked interview activity and hyperresponsibility. Client friendliness evoked agreeable interviewer behavior, and client hostility evoked hostile interviewer behavior.

Beery (1970) found that the affective quality of patients' communication influenced therapists' responses. Therapists tended to respond in a positive and agreeable fashion to a tape-recorded analog of a patient manifesting a friendly attitude and tended to respond in a more hostile fashion when presented with a hostile patient communication. Mueller and Dilling (1968) used the Leary method to examine the reciprocal effects of therapist-client interview behavior. They found that hostile-competitive behavior in therapists was associated with hostile-competitive and passive-resistant behavior in clients and that friendly-dominant behavior in therapists was associated with

support-seeking behavior in clients and low client hostility. Mueller and Dilling concluded that the relationship between therapist hostile-competitive behavior and client "counter-behavior" may be indicative of "therapeutic responsivity."

Other researchers have found that certain patient characteristics elicit particular dispositional responses in therapists (also see Pope, 1977). In a study of sex differences in patients, Parker (1967) found that therapists who scored higher on dominance on the Gough Adjective Check List were more likely to exhibit directive verbalizations and less likely to exhibit nondirective verbalizations. Further, Parker found that therapist dominance was related to the sex of the client. Therapist nondirective behavior was associated with female clients, and therapist directive behavior was associated with male clients. Bohn (1967) examined therapist directiveness in relation to the affective disposition of tape-recorded client presentations and found that therapists were increasingly directive to the "typical," "hostile," and "dependent" clients, respectively.

A second area of empirical research that supports the theories of patient-therapist matching is based on the finding that complementary pairs of therapists and clients are more likely to achieve a successful treatment outcome. Swensen (1967, 1973) scored MMPI profiles of pairs of therapists and patients in order to determine their respective placements on the Leary Circumplex. He found that improvement proportions (improved versus unimproved) were higher when dyad members were complementary on the dominance-submission dimension and when dyad members were similar on the affective dimension

In an extensive application of patient-therapist matching, Berzins (1977) reported a four-year program to develop appropriate pairings of therapists and patients in a university clinic emphasizing short-term treatment. Therapists' personality characteristics were assessed using the Personality Research Form which includes measures of impulse control, ambition, acceptance, dominance, caution, and abasement. Patients were assessed on four interpersonal roles (avoidance of others, turning against self, dependency on others, and turning toward others and self). The overall finding was that complementary pairs were the most successful--i.e., positive therapy outcome was associated with submissive, inhibited, passive patients paired with dominant, expressive, structure-offering therapists and vice versa.

The third area of research supporting the notions of patient-therapist matching concerns the dynamic development of the interpersonal relationships in treatment. Crowder (1972) used Leary's ICL to examine the relationship of therapist "countertransference" to treatment outcome. He found that all therapists demonstrated countertransference (affective) reactions to clients. Successful therapists were more hostile-competitive and less passive-resistant in their countertransference reactions in the early stages of treatment than unsuccessful therapists. Further, successful therapists emitted more friendly-dominant and less hostile-dominant behavior in the later stages of treatment. Crowder concluded that active and spontaneous countertransference early in treatment and resolution of such transference later in treatment characterizes effective psychotherapy.

Dietzel and Abeles (1975) also reported results that are consonant with Carson's and Benjamin's (1974) conceptions of the development of the successful treatment relationship. In examining therapeutic relationships on the Leary dimensions, these authors assessed treatment outcome via clinicians' ratings of pre- and post-treatment MMPI data. Successful client-therapist pairs experienced a period of non-complementarity in the middle phases of treatment. Dietzel and Abeles concluded that these therapists were provoking client change by violating clients' constricted interpersonal behavior and promoting new behavioral modes.

Research examining the relative effectiveness of directive versus nondirective treatment approaches (Orlinsky and Howard, 1978, Strupp and Bergin, 1969, Garfield and Bergin, 1971, Pope, 1977, Mitchell, Bozarth, and Krauft, 1977) also contributes to the notion that clients benefit from an appropriate pairing with treatment dispositions. The focus of this area of research is the examination and identification of the conditions under which directive and/or nondirective treatment approaches are indicated.

In two studies out of the Pennsylvania State University, Ashby, Ford, Guerney, and Guerney (1957) and Baker (1960) examined the therapeutic effectiveness of 'leading' versus 'reflective' treatment styles when paired with certain client characteristics. Ashby et al. (1957) trained clinical psychologists to use leading and reflective therapy styles. They found that clients who were more defensive before therapy tended to behave more defensively in the leading therapy and less defensively in the directive therapy. In addition, clients who entered treatment with a greater need to be deferent felt more defensive in the reflective therapy, and clients who entered treatment with a

greater need for autonomy tended to feel more defensive in the leading therapy. Baker found that the leading style was more effective than the reflective style in reducing overgeneralization by clients and that there was a higher client drop-out rate in the reflective therapy, particularly among clients who were resistive to analyzing problems. He concluded that

> a more leading psychotherapy, which is more interpretive, might help the client to recognize those underlying feelings more quickly and lead to an alteration of his self-generalizations. Reflective therapy appears to require an autonomous mode of behavior on the part of the client. The responsibility which is thrown upon the person in the initial steges of a reflective therapy may be so anxiety provoking that the more resistive client may leave the field. (p. 49)

In separate research publications, Canter (1966, 1971) studied the relationship between authoritarianism and clients' preference for structured versus unstructured treatment. In the 1971 research, Canter measured authoritarianism in patients in a mental hospital via the California F Scale and found that high scores on authoritarianism were positively related to patient preference for structured psychotherapy. He had previously reported the same finding using the same procedures with hospitalized male alcoholics in his 1966 research.

A number of other studies examining the relative effectiveness of directive versus nondirective treatment approaches are coincident with the theories of interpersonal reciprocity. In a study of effectiveness of group therapy among college students, Abramowitz, Abramowitz, Roback, and Jackson (1974) found that clients' scores on Rotter's Internal-External Locus of Control Scale were predictive of the relative effectiveness of directive versus nondirective approaches. More internally oriented clients responded favorably to nondirective treatment, and more externally oriented clients responded favorably

to directive treatment. Along similar lines, Friedman and Dies (1974) and Kilman and Howell (1974) found that client externality on Rotter's I-E dimension was associated with preference for more structure and direction in treatment. Gordon (1957) and Murray (1956) have also found directive treatment approaches to be differentially effective. Gordon found that 'leading' therapy was more effective than "following" therapy in lifting hypnotically induced hostility. Murray found that "active' therapist responses were associated with an increase in patient expression of feeling--both positive and negative--and particularly associated with an increase in patient expression of feeling toward the therapist.

The grounding assumption of the theory and research on patient-therapist matching according to interpersonal style is that psychological treatment is based on the active and reciprocal interaction of the participants. The patient's needs and characteristics (e.g., dependency and hostility) interact with the therapist's needs and characteristics (e.g., dominance and hostility), and, if the match of patient and therapist interpersonal styles is complementary, the pairing is conducive to treatment success. Further, these conditions are especially critical in the early phases of therapy so that the treatment relationship is strong and stable. The task of the therapist throughout the remainder of treatment is conceptualized as avoiding prolonged complementary reciprocation of the patient's interpersonal behaviors by manipulating and "moving' the patient's rigid interpersonal style into other interpersonal operations.

In discussing client dependency in psychotherapy, Snyder (1963) concurred with the above analysis. He recommended that the

psycho-therapist assume a directive and structured treatment orientation in the early phases of therapy with dependent and counterdependent patients in order to encourage dependency for the purpose of building a stable therapeutic relationship. He reasoned that the patient will be unable to change without the security of having his/her dependency needs met, however, the therapist may eventually encourage the patient to assume more responsibility for his/her decisions by relinquishing the directive orientation. Snyder also cautioned the psychotherapist to be aware of client hostility resulting from frustration due to unmet dependency needs. Although he recognized that the patient may not consciously 'want" his/her dependency needs met, Snyder contended that it is the therapist's responsibility to actively engage both the dependency and the resulting hostility.

Other authors have contributed to the notion that successful treatment requires that the therapist actively engage the client's interpersonal disposition. In a review of literature on therapist countertransference, Strupp and Bergin (1969) concluded that, generally speaking, therapist conflicts in relation to hostility, dependency, warmth, intimacy, etc., have an inhibiting effect on the patient's performance in psychotherapy. Mueller and Dilling (1968) concluded that therapeutic responsivity is based on the ability of the therapist to exhibit reciprocal behavioral responses to client overtures, including competitive-hostile behavior.

Bandura, Lipsher, and Miller (1960) examined the therapist responses to patients' expressions of hostility in light of therapists' anxiety about hostility. They found that therapists who scored lower in hostility anxiety were more likely to express hostility directly in

therapy and that therapists with a strong need for approval were more likely to avoid patient hostility than were therapists who were lower in need for approval. Further, therapist expression of hostility was positively related to client expression of hostility and, in complementary fashion, therapist avoidance of hostility led clients to either stop discussion of a particular topic or to change the topic of discussion. This effect was strongest when the therapist was the object of the client's hostility. In this way therapist avoidance led to inhibition of the patient's expiaration of angry feelings. In a review of the literature on the expression of emotion in psychotherapy, Pope (1977) concluded:

> This need surprised no one since the communication of such feelings as anxiety, hostility, or depression by the patient is considered to be central to the psychotherapeutic process The therapist s task is to prompt such communication. However, his capacity to elicit emotional communication is not unrelated to the emotional tone of his own speech. The preceding section presented some evidence that general affective expressiveness by the therapist has a stimulating and evocative effect in the patient (p. 382)

Two other studies support Snyder's analysis of the psychological treatment of dependent and hostile behavior by clients. In research on the way therapists reinforce affective expressions in patients, Winder, Ahmad, Bandura, and Rau (1962) found that (1) in the initial phases of treatment, if a patient's expressions of dependency are approached by the therapist, the patient has a greater likelihood of remaining in treatment, and (2) if expressions of dependency and hostility in patients are approached by the therapist, these behaviors will increase in frequency. In similar fashion to Bandura et al. (1960) and Pope (1977), the authors made reference to the inhibiting effects of therapist anxiety about dependency and hostility and concluded that

the patient will tend to avoid the treatment relationship if there is a lack of either positive or negative reinforcement of dependency. In addition, Winder et al. (1962) drew a distinction between the short-term benefits and the long-term drawbacks of such a complementary disposition.

> But, one must keep in mind that it is the initial and short-term effects of positive reinforcement which are studied here. . . . It may be that in the long run, repeated approach on the part of the psychotherapist might have rather different effects, if indeed psychotherapists do continue to respond with approach. If approach were continued at a high relative rate, patients may come to perceive the psychotherapist as controlling, may simply become submissive and progressively more expressive of dependancy, aggression, and other reinforced categories, may become anxious, or, in line with the catharsis hypothesis, there may be reduced expression regarding topics with repeated ventilation (p. 134)

Russell and Snyder (1963) reported findings similar to Winder et al. in a study of the effect of therapists' anxiety associated with the expression of hostility by clients. They arranged for actors to play the roles of friendly and hostile clients and assessed therapists' responses. The authors found that hostile client behaviors led to significantly greater counselor anxiety than friendly client behavior.

Both Mintz, Luborsky, and Auerbach (1971) and Truax (1971) have provided results that emphasize the importance of expressed hostility by clients to successful treatment outcome. Mintz et al. found that expression of hostility in the early phases of treatment was associated with positive treatment outcome with female clients. In studying the effects of group psychotherapy with juvenile delinquents, Truax also found that client expression of hostility was associated with positive outcome.

This section of the thesis has reviewed the literature in the field of psychotherapy in general on the interpersonal match of therapists and clients and several conclusions are offered. In

particular, hostile and dependent behaviors and attitudes expressed by patients in psychotherapy elicit certain specific reciprocal behaviors and attitudes in treatment personnel (i.e., dominance and hostility). These 'complementary' interpersonal behaviors on the therapist's part may be necessary to establish a strong and stable treatment relationship with the patient. Any inhibition of these reciprocal responses in the therapist may lead to an inhibition of the patient's expression of affect and, consequently, to less successful treatment. Moreover, a distinction is made between the short-term gains of maintaining a complementary disposition toward the patient in terms of the stability of the therapy relationship and the long-term risk of maintaining such a disposition in terms of the rigidity and inflexibility of the treatment relationship.

It is important to note literature specific to the treatment of alcohol abuse which is consonant with these conclusions. Pattison et al. (1977) recognized potential problems associated with the wide range of dispositions in treatment personnel, particularly with hostile and overly permissive therapists. The analysis in this section of the thesis provides a strategic approach to understanding the problems addressed by Pattison et al.

Armor et al. (1978) were more specific in regard to the potential benefits of matching clients with specific personality characteristics with therapists with particular treatment styles. On the basis of research by Glane and Meyers (1963) and Glane (1968), Armor et al. (1978) proposed that treatment approaches based on sympathy, support, and permissiveness may be more beneficial for overtly dependent alcoholics and treatment approaches emphasizing direction and authority may be more

efficient with overtly counterdependent alcoholics. Further, these authors suggested that treatments that are more suitable to alcoholic patients may affect clients' decisions to seek and remain in treatment.

In discussing the interaction between alcoholics and treatment, Armor et al. recommended that

> The major focus of interest here is the issue of client-treatment interactions: the question of whether there are certain treatments that are uniquely successful with certain types of clients because the treatment is 'matched' to the needs of the client. . . . By examining the remission rates of many different client-treatment combinations, we should be able to estimate the benefits that may be expected from such efforts to match clients to appropriate treatments. We should also be able to deal with a second problem: the possibility that treatments may be confounded with client characteristics. (1978, p. 130)

The Problem of Continuation in Treatment and Directiveness in Treatment of Alcohol Abuse

A general conclusion taken from the literature on treatment of alcoholism is that directive approaches to treatment are more effective than less directive approaches. Support for this proposition arises largely from research examining the assumption that, generally speaking, therapy attendance is prerequisite to patient improvement. That is, the longer the alcohol abuser is in treatment, the greater the likelihood that he/she will improve.

The problem of patient "drop out" is not specific to alcoholism treatment. In a review of research on client variables in psychotherapy, Garfield (1978) concluded that there is a positive relationship between length of therapy and outcome in psychotherapy in general and emphasized the importance of treatment meeting the expectations of the client in order to insure that the client will remain in treatment.

Further, Garfield recognized the problem of premature termination in psychotherapy in general. He reviewed several studies of length of treatment and concluded that:

> On the basis of the data presented above, therefore, it is apparent that contrary to traditional expectations concerning length of therapy, most clinic clients remain in therapy for only a few interviews. In practically all of the clinics studied, this pattern was viewed as a problem and was not the result of a deliberately planned brief therapy. Rather, in most instances, the patient failed to return for a scheduled appointment. (p. 197)

Patients dropping out of treatment has long been recognized as a particular obstacle to alcoholism rehabilitation. In a research study spanning five years and examining eight outpatient clinics and related inpatient facilities operated by state alcoholism programs in the eastern United States, Gerard and Saenger (1966) reported that approximately half of the 789 outpatients they studied attended treatment less than four sessions and that only about one-fifth of these patients attended at least ten times during a twelve-month period. Rosenberg and Liftik (1976) found that outpatients required to attend treatment by court probation tended to discontinue treatment with the cessation of such external pressures and that voluntary patients had lower attendance rates than patients required to attend by the court. In a review of literature on patient retention in treatment, Rosenberg, Gerrein, Manohar, and Liftik (1976) concluded that up to 60% of patients in alcoholism treatment fail to return for a second visit and less than 25% remain for more than four visits.

A clear and consistent finding in research on alcoholism treatment is that patients who continue regularly in treatment have higher rates of improvement than patients who drop out of treatment. Powell and Viamontes (1974) and Rosenberg (1974) concluded that patients who

continued in treatment have higher rates of sobriety than patients who discontinued. Baekland and Lundwall (1975) and Armor et al. (1978) also reported that treatment length is positively related to outcome. In a review of 384 studies of psychologically oriented alcoholism treatment published during 1952-1972, Emrick (1975) found that rates of improvement of drinking problems increased as time in treatment increased. Based on the literature presented above, Rosenberg, Gerrein, Manohar, and Liftik (1976), Obitz (1975), Ditman and Cohen (1959), and Miller and Hester (1980) have concluded that rate of retention in treatment should be a primary component in treatment evaluation.

Active and directive treatment approaches have been found to be more successful than less directive approaches in maintaining alcoholics in therapy. Rosenberg, Gerrein, Manohar, and Liftik found that counselors who were more successful in keeping alcoholics in treatment scored higher on cluster 1 of the California Personality Inventory (self-assurance, poise, and ascendancy). Orbitz showed films of directive (Albert Ellis) and non-directive (Carl Rogers) therapists to inpatient male alcoholics and found that the alcoholics overwhelmingly preferred the directive approach for their own treatment. This finding is especially provocative considering that Orbitz's subjects perceived the non-directive approach as more socially desirable--more considerate, warm, friendly, patient, tolerant, sympathetic, and passive--and the directive therapist was seen as more cruel, obnoxious, insulting, annoying, hostile, unreasonable, unpleasant, cold, active, and initiating.

In evaluations of drug treatment of alcohol abuse, Powell and Viamontes (1974), Rosenberg (1974), and Gerrein, Rosenberg, and Manohar (1973) have concluded that 'active' treatment approaches are more effective with alcoholic patients. Gerrein et al. found that patients who received disulfiram under supervision remained in treatment substantially longer than patients who were given a written prescription or who did not receive disulfiram. Powell and Viamontes found that regularity of attendance at an alcohol day hospital program was associated with whether or not patients received medication. Rosenberg found that patients at an alcoholism clinic receiving medication had higher retention rates than patients receiving no medication. These authors concluded that alcoholics may consider "active' treatment, such as prescribing medication, as evidence of interest by treatment personnel and thus respond more favorably to treatment.

As much as court-required attendance to alcoholism treatment can be considered an active and directive treatment approach, and, given the goal of patient retention, court-coerced treatment is an effective intervention. In this regard, Rosenberg and Liftik (1976) and Rosenberg (1974) have reported that patients who were referred for treatment following an alcohol-related offense attended treatment longer than voluntary patients irrespective of treatment approach.

In reference to the hostile and submissive disposition of alcohol abusers and the concomitant dependency conflicts addressed previously in this thesis, several authors have referred to the connection between directive treatment approaches and the dependency conflict between treatment personnel and alcoholics in treatment. Goby, Filstead, and Rossi (1974) found that patients and staff in an

alcohol rehabilitation center had different conceptions of what constituted the most important components of an alcoholism treatment program. They suggested that these differences are a source of conflict and that this conflict results from alcoholics' desire for more direction and the treatment regimen is not responding to these needs. Radar (1975) recommended an active and direct intervention early in the treatment relationship with alcohol abusers. He suggested that if the dependency is not addressed directly, the dependence on the therapist will turn to resentment and distrust, and, if the therapist avoids this direct and overt approach to the dependency he/she is participating in a "paradoxical alliance" with the alcoholic. Silber (1974) considered alcoholics to be generally dependent, immature, impulsive, and lacking a stable sense of identity and therapists to be the wished-for and needed parent. He recommended that the therapist assume the role of parent and that, consequently, the alcoholic will improve because of the directions and suggestions of the longed-for parent who is now present in the form of the therapist. In his review of psychological treatment of alcoholism, Emrick (1975) suggested that:

> . . . some elements in the treatment environment harm alcoholics by eliciting thoughts and feelings of disappointment, abuse, neglect or rejection. This aversive state functions as an antecedent to further drinking, resulting in fewer patients improving . . . . A wiser expenditure of responses might be in the area of developing strategies to involve alcoholics in therapy, any kind of therapy. . . (pp. 94-95)

As noted previously, the problem of patient drop out is not specific to alcoholism treatment. The solutions to this problem also

generalize across clinical issues. In Garfield's (1978) review of client variables in psychotherapy, in general, he recognized that incongruence between patient expectations of treatment and therapist expectations is likely to lead to an unstable treatment relationship and recommended the appropriate match of patient treatment approach as a remedy to premature termination.

Assessing Treatment Outcome

The evaluation of the outcome of treatment of alcohol abuse presents an imposing task for any research project. One conclusion offered previously in this paper is that continuation in treatment is a viable outcome measure. This section of this thesis includes a discussion of the assets and liabilities of other outcome measures, an examination of the interrelationships among outcome measures, and philosophy of evaluating treatment outcome.

The literature on evaluation of outcomes of psychotherapy in general is relevant to this discussion. In a review of the literature on evaluation of treatment outcome, Bergin and Lambert (1978) concluded that measuring kinds of change is the task of treatment evaluation, not whether or not a uniform change occurred. Further, these authors argued for assessment of both behavior changes in clients and of changes in internal states of clients following treatment. Simply stated, Bergin and Lambert contended that change in patients following psychotherapy is multidimensional. These authors also argued for several different kinds of outcome measures following treatment because of the "fallibility" of almost all measures with the single exception of length of treatment because of its objective nature.

Both Bergin and Lambert and Mintz (1977) have discussed the assets and liabilities of therapists' ratings of treatment outcome, and both concluded that therapists' ratings tend to be more positive than other measures. In a review of the literature on the role of the therapist in evaluating treatment outcome, Mintz concluded that, across studies, there is a significant but low level correlation between therapists' ratings and other outcome criteria. In particular, therapist ratings were significantly correlated with client ratings and with pre- and post-adjustment scores (behavior change). The correlations between therapist ratings and client ratings tended to be higher when the same measurement instrument was used by both clients and therapists. Mintz speculated that therapists and clients may evaluate treatment outcome using different criteria, not to discredit or invalidate either source. Mintz offered this conclusion:

> To some degree, then, the therapist ratings do directly reflect improvement, but this improvement is rescaled to take into account the fact that different performance standards exist for different people. Figuratively, it is suggested that the therapist views the patient's improvement, rescales it relative to his expectations for a patient of that type, and then adds a component of personal evaluation whose determinants are unknown at this time. The result is the global outcome measure. (p. 596)

A clear and solid conclusion in the recent literature on the evaluation of alcoholism treatment is that the abstinence criterion is not a valid measure as a singular outcome criterion. Armor et al. (1978) contended that achievement of abstinence is not necessarily related to improvement in other life problems and that uncontrolled alcohol use does not necessarily mean that other life problems do not improve. Thus, these authors suggested the implementation of multiple measures in assessing treatment outcome.

Pattison, Sobell, and Sobell (1977) concurred with Armor et al. but were more detailed and specific in the development of the same conclusions. Their reasoning and some of the data they used to make these conclusions are described below.

In their analysis of the state of the art of alcoholism treatment, Pattison et al. recognized that changes in drinking patterns are a valid outcome goal and moderation in amount of alcohol intake does have a significant correlation with other life improvements but that abstinence is only one of numerous potential drinking outcomes and there is no justification for assuming that it is a more desirable goal. The authors offered this conclusion in reference to abstinence as an outcome criterion:

> . . . it has been assumed that alcohol-dependent persons who do drink cannot be considered to be functioning successfully. This assumption was not examined in most of the earlier evaluation studies, as they ignored other areas of life health. However, even some persons who have been physically dependent on alcohol have been able to change their drinking patterns and attain a successful life adjustment.
>
> Total abstinence may be associated with improvement, no change, or deterioration in other critical areas of total life health. The singular and inappropriate concentration on abstinence as a criterion of successful treatment of alcohol dependence minimizes or obscures treatment methods which should focus on rehabilitation in other areas of life health. In a given case, abstinence may be neither a necessary nor a desirable goal in terms of drinking outcome. (p. 200)

Pattison (1966), in arguing for utilization of multivariant outcomes in evaluating alcoholism treatment, preceded Pattison et al. in concluding that abstinence and mental health bear no necessary relationship. Further, he contended that abstinence may be unnecessary and even contraindicated in treatment of the alcohol abuser. To illustrate the point that abstinence may result in deterioration in overall life adjustment, Pattison described the use of alcohol to

maintain ego integration and alleviate anxiety by the borderline psychotic who would, most probably, become overtly psychotic. If abstinence were required, improvement in functioning in other areas could be prevented.

The interrelationship of other life problems with alcohol problems is a fundamental issue for Pattison et al. in arguing for multivariant outcome measures. They cite an abundance of studies examining other outcome criteria including emotional adjustment, interpersonal relations, social adaptation, vocational stability, and physical health which support the notion "that abstinent alcoholics sometimes show no rehabilitation or even deteriorate in their life adjustment despite abstinence; conversely, nonabstinent alcoholics may show partial or total rehabilitation in terms of these other life variables" (p. 37). Four such studies reviewed by Pattison et al. are presented below.

Pattison, Headley, Gleser, and Gottschalt (1968) used standardized interviews to assess mental health, physical health, interpersonal health, and vocational health in the Cincinnati Alcoholism Clinic and found that abstinence and healthy life adjustment are independent dimensions. In comparing alcoholics whose drinking is mainly controlled with alcoholics whose drinking is mainly uncontrolled, Orford (1973) also found that drinking alone does not account for change in other areas of clients' lives. On the basis of clinical interviews and sociological records, Sobell and Sobell (1976) found that change in

drinking behavior are not necessarily related to changes in vocational functioning and general adjustment. Finally, Pattison, Coe, and Doerr (1973) used the same structured interview procedure developed by Pattison et al. (1968) and found that changes in drinking behavior were not absolutely related to changes in physical health, interpersonal health, and vocational health.

Pattison, Sobell, and Sobell offered this statement in regard to the evaluation of alcoholism treatment outcome:

> Whatever the nature of the drinking variable, there is no necessary correlation with the other variables of life health outcome. Change or no change in drinking status is not highly predictive of changes in these other variables, although there is a positive association between improvement in drinking and improvement in other areas of life health. It is a reasonable clinical assumption that a person will be able to achieve better adaptation in other life areas if his drinking improves. However, there are two confounding sets of possible alternative outcomes: (1) drinking may not improve while there may be improvement in other aspects of life health, (2) drinking may improve while there may be no change or even deterioration in other areas of life health. (1977, p. 207)

One final issue surrounding the assessment of alcoholism treatment outcome should be addressed, the reliability and validity of patient self-reports of drinking behavior. Bergin and Lambert (1978) recognized a "host of biasing procedures" in patient self-report data in general and recommended the use of collateral outcome measures in assessing outcome of psychotherapy.

Pattison, Sobell, and Sobell reviewed studies which investigated the reliability and validity of self-reports of drinking by alcoholism patients and concluded that the existing evidence supports the adequacy

of self-report for use as outcome data. They cited the research by Sobell, Sobell, and Samuels (1974) in which a comparison of legal records with self-reports of prior alcohol-related arrests indicated that such information is accurate and appropriate as a primary information source.

In a review of data from three national programs, Armor et al. (1978) addressed the problems associated with self-reports involving deviant behaviors such as alcoholism. They found that in national surveys the heavier drinkers (e.g., alcoholics) have a greater tendency to underreport their level of alcohol consumption than more moderate users. However, in experimentally controlled situations, alcoholics' self-report is quite accurate when compared with actual measures of blood alcohol concentration. These authors also found that, according to the NIAAA monitoring system, the validity of self-reports of alcoholics at intake 'appears to be quite reasonable, with no substantial overreporting or underreporting' (p. 196). In evaluating the comparison of self-reported drinking, blood alcohol concentration, and clinical assessment in the Rand Report, Armor et al. concluded that self-report is as valid as any other practical measure of drinking behavior.

In concluding their evaluation of the use of self-report of alcohol consumption, Armor et al. presented a 'fairly positive picture':

> First, reliability and validity of the frequency of drinking--and of whether one has drunk at all--appears to be quite satisfactory for behavioral measures of this type whether we are speaking of the general or the alcoholic population. Not only is the consistency reliability high for both groups, but, when self-reports about recent drinking are compared with BAC tests, very few persons who claim no drinking are found to have positive BACs.

> Second, the group validity of the amount of drinking appears to be adequate for the alcoholic population, particularly at the time of entering treatment. This means that one can probably depend on the daily consumption index to give a fairly accurate description of the amount of drinking for groups of alcoholics (e.g., for the clients of a treatment center taken as a whole).
>
> Finally, we must contrast the positive picture with a potential trouble spot. It would appear that amount of consumption is underreported among some of the heavier drinkers in both the general and the alcoholic populations. For alcoholic populations the underreporting appears to be confined to a smaller proportion (than the general population), so that the group validity is not affected to the same degree. Perhaps 10 to 15 percent of alcoholics who have been drinking recently underreport to such an extent that they might be incorrectly classified as nonalcoholic (1978, p. 204)

Final Considerations

The research methodology described in this thesis is designed to assess the interpersonal styles of treatment personnel and alcohol abusers in treatment. Before stating the conclusions and hypotheses generated from this review of literature, two potential biases should be noted.

First, since subjects in this study will be asked to volunteer their participation, certain kinds of alcohol clients may exclude themselves from the research. Garfield (1978) reviewed three studies that found that patients in general psychotherapy who consent to completing pre-therapy questionnaires are more likely to continue in treatment than patients who do not complete pre-therapy questionnaires. One implication of these findings for the current research is that the patients who are most difficult to maintain in treatment may not participate in the study.

A second potential problem is that the interpersonal roles assumed by clients and therapists may be constricted. In a study of client-therapist complementarity, Schiller (1978) found stereotypic role

behavior on the Leary Circumplex in clients and therapists in initial interviews at a university counseling center. According to ratings based on audiotapes of fifteen-minute segments of clinical interviews, Schiller concluded that norms were more predictive of therapist-client behavior than individual differences. Clients scored in the Affiliative-Submissive quadrant 75% of the time, and therapists scored in the Affiliative-Dominant quadrant 96% of the time. In an assessment of alcohol counselors' self-descriptions of their in-session interpersonal behavior, Ansel (1981) found that, although alcohol treatment personnel reported versatility along the Love-Hate dimension of the Leary Circumplex, alcohol counselors reported that they tend to demonstrate primarily Affiliative-Dominant behavior in treatment interactions.

Given these role prescriptions, the sociological requirements of the treatment interaction may make it difficult for therapists and alcohol abusers in treatment to present hostile behaviors. Perhaps the extent to which clients and therapists demonstrate hostile interpersonal styles in alcohol treatment should be considered in reference to the role prescriptions of the client-therapist interaction in general.

Conclusions and General Hypotheses

Briefly stated, the conclusions reached in the previous section of this thesis are that

1. In initial interactions with therapists, alcohol abusers will tend to present hostile-dependent dispositions.
2. In initial interactions with alcohol abusers in treatment, therapists will tend to present hostile-dominant dispositions

3. Therapist-client dyads in alcohol abuse treatment with higher rates of interpersonal complementarity will have higher client attendance rates (more stable relationships) than therapist-client dyads with lower rates of interpersonal complementarity

4. Alcohol abusers interacting with therapists demonstrating more affiliative-dominant behaviors will show more improvement in life adjustment than alcohol abusers interacting with therapists demonstrating less affiliative-dominant behaviors.

5. Alcohol abusers interacting with therapists demonstrating more dominant interpersonal behaviors will show more improvement in drinking behavior than alcohol abusers interacting with therapists demonstrating less dominant interpersonal behaviors.

6. Alcohol abusers with more rigid interpersonal styles in treatment interactions will demonstrate lower general adjustment than alcohol abusers with less rigid interpersonal styles in treatment interactions.

7. Alcohol abusers in therapist-client dyads with higher rates of interpersonal complementarity will demonstrate more improvement in drinking behavior than alcohol abusers in therapist-client dyads with lower rates of interpersonal complementarity.

8. Alcohol abusers in therapist-client dyads demonstrating changes in interpersonal styles within treatment interactions will show more improvement in general adjustment than alcohol abusers in therapist-client dyads either demonstrating less change or no change in interpersonal styles within treatment interactions.

9. Client improvement in drinking pattern will be positively related to client improvement in general adjustment. However, some alcohol abusers will demonstrate improvement in drinking behavior or general adjustment but not both.

CHAPTER III

METHOD

Subjects

Treatment staff from six different centers that offer services for alcohol abusers were contacted. Of those, staff from three centers consented to participate in the project. The expressed reasons for not participating provided by the other three centers tended to involve a reaction to the time and energy involved in such a project. Two of these agencies also expressed some philosophical reservations such as "not believing" in research.

The agencies that participated were two alcohol treatment services out of the Northern Nebraska Comprehensive Mental Health Center in Norfolk, Nebraska and in Columbus, Nebraska and the Alcoholism Treatment Center out of the Sunset Mental Health Center in Brooklyn, New York. All three of these agencies are based in community mental health centers. None of them offer inpatient treatment but each is frequently involved in referrals to inpatient programs.

Within agencies, some staff members decided not to participate from the start of the project and some staff members who decided to participate in the beginning actually did not participate. Seven staff members are included in this study. They represent an age range from the mid-twenties to the mid-forties. Two of them had previously received the Ph.D. in psychology, and two were in the final stages of doctoral programs in psychology. Two others were ex-abusers themselves and both had

received formal training in the treatment of alcohol abuse. The final staff member who participated had previously received the M.A. psychology. Only one of the participating staff members did not have extensive experience in treating alcohol abusers. Each of the other staff members had at least one year experience within their treatment program. Two of the participating treatment personnel were female.

Twenty-four individuals in treatment for alcohol abuse were included in the project. Fourteen attended treatment on a voluntary basis, and ten were required to attend treatment by the court. All of the clients were caucasion; only two were female. They ranged in age from eighteen to sixty-four.

The twenty-four treatment cases were selected from only psychotherapeutic cases involving alcohol abuse with the potential of long-term individual therapy. Since length of treatment was a variable to be considered in this study, all cases initially included that resulted in outcome data were examined regardless of whether the patient left treatment prior to completion. Each client agreed to participate on the basis of receiving fifteen dollars compensation following completion of the post-treatment questionnaires.

Instruments

Current Adjustment Rating Scale (CARS)

In a review of techniques and issues in assessment of treatment outcome, Bergin and Lambert (1978) presented evaluation instruments that they considered to be useful and valid. One such instrument that has been used extensively is the Current Adjustment Rating Scale developed by Miles, Barrabee, and Finesinger (1951a) and later adapted by Truax (Berzins, Bednar, and Severy, 1975).

The CARS device can be completed by clinical observers and significant others as well as by therapists and patients under differing instructional sets. The scale consists of 14 nine-point Likert-type scales with which the respondent can evaluate the patient's current functioning (e.g., overall adjustment, recent changes, extent of living up to personal and vocational potential, ability to work steadily), various current satisfactions (e.g., life, work, sex, leisure-time activities, relationships with friends, relatives, spouse, partners), and aspects of the patient's social stimulus value (e.g., likeability to others, likeability to the therapist, others' satisfactions in relationships involving the patient). The sum of the ratings across all 14 areas represents the patient's current life adjustment with high scores indicating favorable adjustment

Miles, Barrabee, and Finesinger (1951a, 1951b) and Berzins, Bednar, and Severy (1975) provided data that support the reliability and validity of the CARS instrument. Miles et al. (1951a) examined ten case studies across four independent raters for both "initial" and "follow-up" ratings on occupational adjustment, interpersonal relationships, marital adjustment, and sexual adjustment. The four observers agreed exactly in 20% of the ratings, showed a disagreement of one point in the scale in 58%, and differed by two points in the scale in 22%. No disagreements by more than two points occurred. These differences were partially discounted when the separate ratings were combined into an assessment of total social adjustment.

Two of the raters repeated their appraisals of 15 cases after a lapse of six to eight months to check consistency. On the four

dimensions, one rater checked his own results exactly in 74% of the instances and differed by a single point in 26%. The second rater checked his own results exactly in 70% and showed a discrepancy of one point in 30%

In addition, Miles et al. (1951b) reported a "close correlation' between clinicians' evaluations and patients' self-evaluations on the CARS dimensions.

Berzins et al. (1975), in a study of multi-source evaluations of therapeutic outcome, concluded that the CARS instrument may be the most promising instrument they examined because of its strong relationship to other measures of improvement and because of its brevity. The authors used the MMPI, Psychiatric Status Schedule, Rogers and Dymond's Q Sort, and the CARS device to study the relationship among outcome measures in 79 client-therapist dyads. Sources of ratings came from therapists, clients, and trained observers. Positive outcomes were recorded across instruments and across sources of ratings

Khavari Alcohol Test (KAT)

The extent and pattern of alcohol consumption by particular drinkers was assessed via the Khavari Alcohol Test (Khavari and Farber, 1978) which is an expanded and modified version of a quantity-frequency index of alcohol consumption developed by Calahan, Cisin, and Crossley (1969). The KAT is designed to provide a comprehensive description of the respondent's drinking pattern.

> A variety of other information can be gleaned from the profile, including (1) the within-subject (or group) variation of drinking. By having separate scales for the three beverages, any differences in the amount or pattern of drinking beer, wine and spirits can be easily assessed. (2) The degree to which an

individual (or group) engages in 'spurt' or 'binge" drinking, as opposed to continuous drinking. Comparison of the usual and maximum frequency and volume scales can indicate the variability of drinking over time. (3) Regarding the peculiar pattern of investigation, and individual's (or group's) aggregate volume of consumption (the Annual Absolute Alcohol Intake scale) can be compared with the population's mean and the extent of its deviance determined statistically. (Khavari and Farber, pp. 1531-1532).

The reliability and validity of such self-report data is discussed in a previous section of this thesis.

Leary Interpersonal Check List

Interpersonal operations by clients and therapists within the current research was assessed with the Leary Interpersonal Check List (Leary, 1957). The derivation of this instrument was described previously in this thesis. Extensive reliability and validity data have been described by McLemore and Benjamin (1979), Benjamin (1974), Carson (1969), Leary (1957), Lorr and McNair (1963, 1965), Lorr, Bishop, and McNair (1965), LaForge, Leary, Naboisek, Coffey, and Freedman (1954), Leary and Coffey (1955), Freedman, Leary, Ossorio, and Coffey (1951), and LaForge and Suczek (1955).

The form of the ICL that was used to develop this research project (Form IV) comprises 128 items--eight for each of the sixteen interpersonal operations. The intensity dimension is built into the check list so that each of the sixteen interpersonal variables is represented by a four-point scale. For each variable there are one intensity 1 item which reflects "a mild of necessary amount of the trait," three intensity 2 items which reflect "a moderate or appropriate amount of the trait," three intensity 3 items which reflect 'a marked or inappropriate amount of the trait," and one intensity 4 item which reflects "an extreme amount of the trait."

Rogers and Dymond Outcome Evaluation Form

In a review of therapist evaluation of treatment outcome, Bergin and Lambert (1978) concluded that the rating scale developed by Rogers and Dymond (1954) may be the measure of choice for assessment made directly by the therapist as it has been shown to correlate positively with other more sophisticated and time-consuming measures (Cartwright, Kirtner, and Fiske, 1963 and Lorr, McNair, Michaux, and Raskin, 1962).

For the purposes of the investigation of alcoholism treatment, one item was added by this author (Ansel, 1981). This additional item is designed to assess therapists' judgment of drinking outcome. The Rogers and Dymond Scale was based on a research project examining "therapeutic movement" in 23 treatment cases. The particular items adapted for this study were intercorrelated with measures of process variables and were found to correlate positively with two other outcome measures (Thematic Apperception Test and a self-description Q Sort measure) in the research by Rogers and Dymond.

Behavioral Analysis System

Client-therapist interactions were examined in the current research via the interpersonal system of behavioral analysis developed by Leary (1957) and elaborated by Freedman, Leary, and Coffey (1951) and LaForge and Suczek (1955). The particular method of audiotape analysis used in this research is adapted from a procedure originally presented by Dietzel and Abeles (1975)

According to this system of interaction analysis, each response unit (an uninterrupted speech) by a therapy participant is scored and located in one of the four Leary quadrants. Raters were instructed to empathize in order to rate responses according to the position of the person to whom the behavior was directed.

These ratings on the Interpersonal Scoring System provide the data from which therapist complementarity indices were calculated. This index, developed by Dietzel and Abeles, is designed to reflect the level of response by response complementarity exhibited by a therapist. To accomplish this the authors constructed a 4 x 4 interaction matrix. Each interaction cell is weighted (3,2 or 1) to indicate the level of complementarity in a particular behavioral exchange. The complementarity index for a specific segment of interchange between a client and therapist is calculated by inserting the proportions of rated interactions into the appropriate cells, multiplying each proportion by the cell weighting, and summing the weighted proportions across all 16 cells. Larger complementary index values indicate higher levels of therapist-client complementarity.

In addition, interpersonal behaviors according to the Leary dimensions were assessed for clients and therapists for each audio-taped segment of psychotherapy. These interpersonal operations were calculated in terms of the proportion of responses in each of the four Leary quadrants.

Procedure for Data Collection

In each agency that participated in the research, the project was presented in a formal presentation at a staff meeting. The focus of

this presentation was on the practical requirements that the staff were asked to meet for data collection. The development of the thesis and the experimental hypotheses were not discussed. At the end of the presentation, the Informed Consent Form for Counselors (see Appendix A) was presented to the staff so that they could indicate whether or not they were willing to participate.

Each agency was provided with a set of cover sheets to organize the data for each client-therapist dyad. The cover sheet (see Appendix B) identified the counselor, the client, the age of the client, the sex of the client, whether or not the client was required to attend treatment by the court, the dates of each session that the client attended, and a series of reminders as to how to best facilitate data collection. In addition, arrangements were made for each counselor who consented to participate to receive a tape recorder and a set of audiotapes prior to each session with clients in the study.

The receptionists at each of the mental health clinics involved in the project were instructed to provide the Informed Consent Form (see Appendix C) to each of the clients of consenting counselors prior to the initial interview. Each client who consented to participate was asked to complete the CARS and the KAT instruments prior to the initial meeting with the counselor. The version of the CARS instrument that was presented prior to treatment appears in Appendix D.

Every counseling session in each consenting client-therapist dyad was audiotaped and labelled by the counselor with the following information: name of counselor, client identification, date of the interview, and sequence of the interview. Although every audiotape was not

scored, every session was audiotaped to insure that the final treatment interview was recorded.

Following the sixth interview or following cessation of treatment, if counseling was terminated prior to the sixth interview, the post-treatment data was collected. Counselors were asked to evaluate the outcome of treatment on the adapted version of the Rogers and Dymond Outcome Evaluation Form. Clients were asked to evaluate their drinking behavior on the KAT instrument and their general life adjustment on the CARS instrument relative to their life experiences since entering treatment with their current counselor. Instructions for this procedure were provided on a cover sheet that was presented to the client prior to completing the post-treatment questionnaires (see Appendix E). An item was added to the CARS instrument for post-treatment administration. This version of the CARS appears in Appendix F. If the client terminated treatment before designating a final session, the post-treatment questionnaires were mailed to the client along with a request for completion. Client-therapist dyads who completed only a single treatment session were included in the data analysis if post-treatment data was procured.

Treatment outcome was evaluated from three sources: (1) differences between client pre- and post-scores on the CARS to evaluate change in general adjustment, (2) differences between client pre- and post-scores on the KAT to evaluate change in drinking behavior, and (3) therapist evaluation of outcome on the Rogers and Dymond scale.

Procedure for Scoring the Audiotapes

As mentioned previously, every counseling session for each client-therapist dyad was audiotaped. Only the first, final or sixth, and middle (third or fourth) sessions between the first and final sessions, however, were rated. Fifteen-minute segments from these sessions were scored. The rated segments began at fifteen minutes into the interview and ended at thirty minutes into the interview.

Two graduate students from a doctoral program in Clinical Psychology who had training and experience in professional counseling were trained to rate audiotapes according to the Leary dimensions. The dimensions were introduced in written form to both raters and the criteria to designating quadrants were discussed informally. Practice tapes were rated until the agreement rate on consecutive tapes exceeded 75 per cent. Dietzel and Abeles (1975) found a mean agreement rate over 82 per cent across raters in similar research. The raters were "blind" to the experimental hypotheses as well as to the sequence of the session being rated.

The calculations of complementarity according to the Behavioral Analysis System were conducted by the principal investigator based on the evaluations of the sessions made by the raters.

Experimental Hypotheses and Procedures for Calculation

1. In initial therapy sessions, alcohol abusers will present interpersonal operations in equal proportions on the Leary dimensions. This hypothesis will be rejected if alcohol abusers in treatment demonstrate primarily hostile dependent operations in initial sessions. The rate of responding in each Leary quadrant was calculated

by summing the number of utterances in each category for both raters and dividing by the number of total responses for both raters

2 In initial therapy sessions with alcohol abusers, treatment personnel will present interpersonal operations in equal proportions on the Leary dimensions. This hypothesis will be rejected if treatment personnel demonstrate primarily hostile dominant operations in initial sessions. The same calculation procedure was used to determine the proportion of responses in each quadrant as described in the first hypothesis.

3 Rates of interpersonal complementarity in therapist-client dyads according to the Behavioral Analysis System will be unrelated to treatment attendance rates. This hypothesis will be rejected if therapist-client dyads with higher rates of interpersonal complementarity have higher attendance rates than therapist-client dyads with lower rates of interpersonal complementarity

4 Rates of affiliative-dominant behavior in therapists according to the Leary dimensions will be unrelated to improvement in general adjustment in alcohol abusers according to differences in pre- and post-treatment scores on the CARS instrument and according to therapist ratings on the Rogers and Dymond Outcome Evaluation instrument. This hypothesis will be rejected if alcohol abusers interacting with therapists demonstrating more affiliative dominant operations show larger improvement on these ratings than alcohol abusers interacting with therapists demonstrating less affiliative dominant behaviors.

5 Rates of dominant behavior in therapists according to the Leary dimensions will be unrelated to improvement in drinking behavior in alcohol abusers according to differences in pre- and post-treatment

scores on the KAT and according to therapist ratings on the Rogers and Dymond Outcome Evaluation Form. This hypothesis will be rejected if alcohol abusers interacting with therapists demonstrating more dominant operations show greater improvement in drinking behavior than alcohol abusers interacting with therapists demonstrating less dominant operations.

5. The range of alcohol abusers' interpersonal operations on the Leary dimensions in treatment interactions will be unrelated to improvement in general adjustment according to differences in pre- and post-treatment scores on the CARS Instrument and according to therapist ratings on the Rogers and Dymond Outcome Evaluation Form. This hypothesis will be rejected if alcohol abusers demonstrating a more limited range of interpersonal operations in treatment interactions show less improvement in general adjustment than alcohol abusers demonstrating a greater range of interpersonal operations in treatment interactions. The range of interpersonal operations was calculated by summing the absolute values of the differences between the proportion of responses in each quadrant in each session and the rate expected by chance (.250). Lower values are associated with a greater range of interpersonal operations.

7. Rates of interpersonal complementarity in therapist-client dyads according to the Behavioral Analysis System will be unrelated to improvement in drinking behavior according to differences in pre- and post-treatment scores on the KAT and according to therapist ratings on the Rogers and Dymond Outcome Evaluation Form. This hypothesis will be rejected if alcohol abusers in therapist-client dyads with higher rates of interpersonal complementarity demonstrate

more improvement in drinking behavior than alcohol abusers in therapist-client dyads with lower rates of interpersonal complementarity.

8 Changes in predominant interpersonal operations by alcohol abusers in treatment interactions according to the Leary dimensions will be unrelated to improvement in general adjustment according to pre- and post-treatment scores on the CARS instrument and according to therapist ratings on the Rogers and Dymond Outcome Evaluation instrument. This hypothesis will be rejected if alcohol abusers demonstrating greater change in interpersonal operations in treatment interactions show more improvement in general adjustment than alcohol abusers demonstrating less change in interpersonal operations in treatment interactions. Change in the rates of operations in each Leary quadrant were calculated by summing the absolute values of the differences between the proportion of responses in each quadrant from session to session. The difference in rate in each quadrant was calculated by obtaining the differences from the initial to the middle session, from the initial to the final session, and from the middle to the final session. Higher values are associated with greater change in the kind of interpersonal behavior presented during sessions.

9 Client improvement in drinking behavior according to differences in pre- and post-treatment scores on the KAT instrument and according to therapist ratings on the Rogers and Dymond Outcome Evaluation Form will be unrelated to client improvement in general adjustment according to differences in pre- and post-treatment scores on the CARS instrument and according to therapist ratings on the Rogers and

Dymond Outcome Evaluation Form. This hypothesis will be rejected if clients demonstrating greater improvement in drinking behavior show more improvement in general adjustment than clients demonstrating less improvement in drinking behavior.

All of the statistical analyses in this thesis were conducted using the .05 level of significance as a cut off point for rejecting the null hypothesis.

CHAPTER IV

RESULTS

Because the length of treatment was a primary variable considered in this research, whether clients were required to attend alcohol treatment by the court (n=10) or they attended voluntarily (n=14) was monitored. Further, these two groups were compared on a variety of other measures within the project to determine essential differences.

A series of multiple regression analyses were used to compare voluntary and court referred clients along the following dimensions: number of sessions attended, clients' rate of responding in the hostile submissive quadrant in initial sessions, counselors' rate of responding in the hostile dominant quadrant in initial sessions, rates of complementarity in initial sessions, score on the Current Adjustment Rating scale prior to treatment, score the Khavari Alcohol Test prior to treatment, score on the Rogers and Dymond Outcome Evaluation Form following treatment, score on the Rogers and Dymond Outcome Evaluation Form specific to drinking following treatment, the difference between pre- and post-treatment scores on the Current Adjustment Rating Scale, and the difference between pre- and post-treatment scores on the Khavari Alcohol Test. These analyses are presented in Tables 1 through 10.

Only one of these statistical comparisons sound significant differences between voluntary clients and clients required to attend treatment by the court. Voluntary clients tended to report greater alcohol consumption on the Khavaris Alcohol Test prior to treatment (mean equal

TABLE 1

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO LENGTH OF TREATMENT

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	4.14405	4.14405	.7941	0.3825
Residuals	22	114.814	5.21883		
Total	23	118.958			

TABLE 2

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO THE RATE OF CLIENT HOSTILE SUBMISSION IN INITIAL SESSIONS

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	6840.01	4840.01	.3763	0.5459
Residuals	22	399930	18178.6		
Total	23	406770			

TABLE 3

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO THE RATE OF COUNSELOR HOSTILE DOMINANCE IN INITIAL SESSIONS

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	29678.6	29678.6	1.093	0.3072
Residuals	22	597523	27160.1		
Total	23	627202			

TABLE 4

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO THE RATE OF COMPLEMENTARITY IN INITIAL SESSIONS

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	115.144	115.144	1131	0.7398
Residuals	22	22387.8	1017.63		
Total	23	22503.0			

TABLE 5

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO PRE-TREATMENT SCORE ON THE CURRENT ADJUSTMENT RATING SCALE

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	66.8678	66.8678	.07728	0.7836
Residuals	22	19034.8	865.216		
Total	23	19101.6			

TABLE 6

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO PRE-TREATMENT SCORES ON THE KHAVARI ALCOHOL TEST

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	4733.38	4733.38	8.731	0.0073
Residuals	22	11925.5	542.112		
Total	23	16659.8			

TABLE 7

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO SCORES ON THE ROGERS AND DYMOND OUTCOME EVALUATION FORM

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	91.3440	91.3440	2.710	0.1140
Residual	22	741.614	33.7097		
Total	23	832.958			

TABLE 8

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO SCORES ON THE ROGERS AND DYMOND OUTCOME EVALUATION FORM SPECIFIC TO DRINKING

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	.0761902	.0761902	.03675	0.8458
Residuals	22	43.2571	1.96623		
Total	23	43.3333			

TABLE 9

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO THE DIFFERENCE BETWEEN PRE- AND POST-TREATMENT SCORES ON THE CURRENT ADJUSTMENT RATING SCALE

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	618 858	618 858	1 486	0 2357
Residuals	22	9162 10	416 459		
Total	23	9780 96			

TABLE 10

ANALYSIS OF VARIANCE FOR THE REGRESSION FOR VOLUNTARY VERSUS COURT REFERRED CASES ACCORDING TO THE DIFFERENCE BETWEEN PRE- AND POST-TREATMENT SCORES ON THE KHAVARI ALCOHOL TEST

(n=24)

Source of Variation	Degrees of Freedom	Sum of Squares	Mean Square	F	Tail Probability
Regression	1	524 876	524 876	8280	0 3727
Residuals	22	13946 5	633 930		
Total	23	14471 3			

to 66 295) than court referred clients (mean equal to 37 900) All other comparisons did not find the groups to be significantly separate. Consequently, all additional statistical analyses are based on an overall sample combining both voluntary and court referred cases

Interpersonal Styles During Sessions

Repeated Measures Analyses of Variance were used to test for overall differences in the rates of responding in each Leary quadrant during sessions for both clients and counselors. Individual post hoc comparisons were conducted using the Scheffé method of multiple comparisons between means.

Table 11 shows the analysis for the first experimental hypothesis which revealed a significant overall effect (F 3,92) - 38.66, $p < .0000$). Post hoc analysis of the predicted single difference according to this hypothesis (that clients in initial sessions of alcohol treatment would display predominantly hostile submissive operations) revealed a value with 3 degrees of freedom of 90 085 ($p < .01$). Table 13 displays additional single comparisons using a critical value of t with 3 and 23 degrees of freedom of 9.09 for $p < .05$ and 14.28 for $p < .01$.

TABLE 11

ANALYSIS OF VARIANCE FOR CLIENTS' RESPONDING
PER QUADRANT IN INITIAL SESSIONS

(n=24)

Source	Sum of Squares	Degrees of Freedom	Mean Square	F	Tail Probability
Quadrant	1965598	3	655200	38.66	0.0000
Error	1569101	92	16950		
Total	3524700	95			

TOTAL 12

MEAN RATES OF RESPONDING PER QUADRANT FOR
CLIENTS IN IHITIAL SESSIONS

(n=24)

Quadrant	Mean	Standard Deviation
Hostile Dominant	77.83	82.90260
Hostile Submissive	467.4	162.6832
Affiliative Dominant	181.8	139.1350
Affiliative Submissive	268.8	122.8406

TOTAL 13

IHDIVIDUAL COMPARISONS PER QUADRANT FOR CLIENTS'
RESPONSES DURIHG INITIAL SESSIONS

(n=24)

Comparison	t value	Tail Probability
Hostile Dominant-Hostile Submissive	-1074.441	.01
Hostile Dominant-Affiliative Dominant	-7.653	N.S.
Hostile Dominant-Affiliative Submissive	-25.815	.01
Hostile Submissive-Affiliative Dominant	577.468	.01
Hostile Submissive-Affiliative Submissive	27.924	.01
Affiliative Dominant-Affiliative Submissive	-6.359	N.S.

Table 14 shows the analysis for the second experimental hypothesis which also revealed a significant overall effect ($F(3,92) = 124.5$, $p = .0000$). Post hoc analysis of the predicted single difference according to this hypothesis (that counselors in initial sessions of alcohol treatment would display predominantly hostile dominant operations) revealed a t value with 3 degrees of freedom of 33.908 ($p < .01$). Table 16 displays additional single comparisons using the same critical values for t as were used in the analysis for client means.

TABLE 14

ANALYSIS OF VARIANCE FOR COUNSELORS' RESPONDING PER QUADRANT IN INITIAL SESSIONS

(n=24)

Source	Sum of Squares	Degrees of Freedom	Mean Square	F	Tail Probability
Quadrant	4364916	3	1455000	124.5	0.0000
Error	1075040	92	11690		
Total	5439956	95			

TABLE 16

MEAN RATES OF RESPONDING PER QUADRANT FOR COUNSELORS IN INITIAL SESSIONS

(n=24)

Quadrant	Mean	Standard Deviation
Hostile Dominant	598.2	149.7113
Hostile Submissive	26.17	41.91157
Affiliative Dominant	225.3	121.0473
Affiliative Submissive	150.5	99.98509

TABLE 16

INDIVIDUAL COMPARISONS PER QUADRANT FOR
COUNSELORS' RESPONSES DURING INITIAL SESSIONS

(n=24)

Comparison	t value	Tail Probability
Hostile Dominant-Hostile Submissive	336.894	.01
Hostile Dominant-Affiliative Dominant	142.742	.01
Hostile Dominant-Affiliative Submissive	205.750	.01
Hostile Submissive-Affiliative Dominant	-40.704	.01
Hostile Submissive-Affiliative Submissive	-15.868	.05
Affiliative Dominant-Affiliative Submissive	5.743	N.S.

Similar statistical analyses were used to examine client and counselor behavior in middle and final sessions. (See Tables 17-28.) Because of early termination in 11 of the treatment cases only 13 treatment cases were used for these analyses. All of the treatment dyads who were involved in middle sessions were also involved in final sessions. No predictions were made regarding a single difference among the means within each analysis so only individual comparisons were conducted using critical values of t with 3 and 12 degrees of freedom of 10.47 for $p < .05$ and 17.85 for $p < .01$.

TABLE 17

ANALYSIS OF VARIANCE FOR CLIENTS' RESPONDING
PER QUADRANT IN MIDDLE SESSIONS

(n=13)

Source	Sum of Squares	Degrees of Freedom	Mean Square	F	Tail Probability
Quadrant	386189.3	3	128700	6.945	0.0006
Error	889660.7	48	18530		
Total	1275850	51			

TABLE 18

MEAN RATES OF RESPONDING PER QUADRANT
FOR CLIENTS IN MIDDLE SESSIONS

(n=13)

Quadrant	Mean	Standard Deviation
Hostile Dominant	114.5	123.6781
Hostile Submissive	353.5	177.3014
Affiliative Dominant	258.6	120.9845
Affiliative Submissive	273.6	113.0004

TABLE 19

INDIVIDUAL COMPARISONS PER QUADRANT FOR
CLIENTS' RESPONSES DURING MIDDLE SESSIONS

(n=13)

Comparison	t value	Tail Probability
Hostile Dominant-Hostile Submissive	-20.037	.01
Hostile Dominant-Affiliative Dominant	-7.284	N.S.
Hostile Dominant-Affiliative Submissive	8.879	N.S.
Hostile Submissive-Affiliative Dominant	3.159	N.S.
Hostile Submissive-Affiliative Submissive	2.039	N.S.
Affiliative Dominant-Affiliative Submissive	0.079	N.S.

TABLE 20

ANALYSIS OF VARIANCE FOR COUNSELORS' RESPONDING
PER QUADRANT IN MIDDLE SESSIONS

(n=13)

Source	Sum of Squares	Degrees of Freedom	Mean Square	F	Tail Probability
Quadrant	162D773	3	540300	33.53	0.0000
Error	773352.3	48	16110		
Total	235412.5	61			

TABLE 21

MEAN RATES OF RESPONDING PER QUADRANT FOR COUNSELORS IN MIDDLE SESSIONS

(n=13)

Quadrant	Mean	Standard Deviation
Hostile Dominant	510.5	186.6791
Hostile Submissive	36.69	43.57634
Affiliative Dominant	304.5	141.5372
Affiliative Submissive	158.4	87.55145

TABLE 22

INDIVIDUAL COMPARISONS PER QUADRANT FOR COUNSELORS' RESPONSES DURING MIDDLE SESSIONS

(n=13)

Comparison	t value	Tail Probability
Hostile Dominant-Hostile Submissive	90.655	.01
Hostile Dominant-Affiliative Dominant	17.122	.05
Hostile Dominant-Affiliative Submissive	50.021	.01
Hostile Submissive-Affiliative Dominant	-28.936	.01
Hostile Submissive-Affiliative Submissive	-5.977	N.S.
Affiliative Dominant-Affiliative Submissive	8.612	N.S.

TABLE 23

ANALYSIS OF VARIANCE FOR CLIENTS' RESPONDING PER QUADRANT IN FINAL SESSIONS

(n=13)

Source	Sum of Squares	Degrees of Freedom	Mean Square	F	Tail Probability
Quadrant	417189.2	3	139100	8.270	0.0002
Error	807096.8	48	16810		
Total	122428.8	51			

TABLE 24

MEAN RATES OF RESPONDING PER QUADRANT FOR CLIENTS IN FINAL SESSIONS

(n=13)

Quadrant	Mean	Standard Deviation
Hostile Dominant	106.4	71.07454
Hostile Submissive	285.2	128.5236
Affiliative Dominant	350.8	177.0137
Affiliative Submissive	257.8	118.9188

TABLE 25

INDIVIDUAL COMPARISONS PER QUADRANT FOR CLIENTS' RESPONSES DURING FINAL SESSIONS

(n-13)

Comparison	t value	Tail Probability
Hostile Dominant-Hostile Submissive	-12.362	.05
Hostile Dominant-Affiliative Dominant	-23.097	.01
Hostile Dominant-Affiliative Submissive	- 8.863	N.S.
Hostile Submissive-Affiliative Dominant	- 1.664	N.S.
Hostile Submissive-Affiliative Submissive	0.290	N.S.
Affiliative Dominant-Affiliative Submissive	3.344	N.S.

TABLE 26

ANALYSIS OF VARIANCE FOR COUNSELORS' RESPONDING PER QUADRANT IN FINAL SESSIONS

(n-13)

Source	Sum of Squares	Degrees of Freedom	Mean Square	F	Tail Probability
Quadrant	1338646	3	446200	23.63	0.0000
Error	906499.7	48	18890		
Total	2245146	51			

TABLE 27

MEAN RATES OF RESPONDING PER QUADRANT FOR COUNSELORS' IN FINAL SESSIONS

(n=13)

Quadrant	Mean	Standard Deviation
Hostile Dominant	473.4	188.7660
Hostile Submissive	27.00	33.4907
Affiliative Dominant	290.8	171.4276
Affiliative Submissive	209.1	96.86370

TABLE 28

INDIVIDUAL COMPARISONS PER QUADRANT FOR COUNSELORS' RESPONSES DURING FINAL SESSIONS

(n=13)

Comparison	t value	Tail Probability
Hostile Dominant-Hostile Submissive	68.569	.01
Hostile Dominant-Affiliative Dominant	11.473	.05
Hostile Dominant-Affiliative Submissive	24.037	.01
Hostile Submissive-Affiliative Dominant	-23.946	.01
Hostile Submissive-Affiliative Submissive	-11.410	.05
Affiliative Dominant-Affiliative Submissive	2.297	N.S.

One clear conclusion from the analysis of counselor behavior in the middle and final sessions is that the counselors in this project continued to present predominently hostile dominant operations throughout all six sessions. Clients, on the other hand, were more flexible in their interpersonal behaviors as treatment progressed. Although they tended to present primarily hostile submissive behaviors in initial sessions, by the sixth session they were presenting more affiliative dominant operations than hostile submissive operations. This latter finding was not

significant but clearly suggests greater interpersonal flexibility on the part of clients in treatment as compared to counselors.

Complementarity

A Repeated Measures Analysis of Variance was used to test for overall differences in the rates of complementarity across sessions for treatment dyads who continued through the middle and final sessions (n=13) (see Table 29). This analysis revealed a significant overall effect ($F(2,38) = 5.606$, $p < .0076$). Individual post hoc comparisons were made using the Scheffe method with critical t with 2 and 12 degrees of freedom of 7.78 for $p < .05$ and 13.86 (see Table 31).

TABLE 29

ANALYSIS OF VARIANCE FOR RATES OF COMPLEMENTARITY ACROSS SESSIONS

(n=13)

Source	Sum of Squares	Degrees of Freedom	Mean Square	F	Tail Probability
Session	2766.531	2	1383	5.606	0.0076
Error	8883.219	36	246.8		
Total	11649.75	38			

TABLE 30

MEAN RATES OF COMPLEMENTARITY ACROSS SESSIONS

Session	Mean	Standard Deviation
Initial	12.413	11.69319
Middle	12.223	19.45244
Final	2.248	15.00470

TABLE 31

INDIVIDUAL COMPARISONS PER SESSION FOR RATES OF COMPLEMENTARITY

(n=13)

Comparison	t value	Tail Probability
Initial - Middle	9.507	.05
Initial - Final	7.170	N.S.
Middle - Final	0 165	N.S.

These results suggest that the rate of complementarity tended to be highest in initial sessions, then decrease in the middle phase of treatment, and continue at a stable rate through the final phase of treatment.

The third experimental hypothesis (that client attendance rates will be related to rates of complementarity) was tested by examining the correlation of the Complementarity Index in the initial session and the number of sessions attended by the client. The mean number of sessions attended was 3.7083. This correlation was R= 64051 with a corresponding t value with 23 degrees of freedom of 3.91 ($p < .0035$ based on a one-tailed test). This finding indicates that clients in counselor-client dyads with higher rates of complementary during initial sessions tended to stay in treatment longer.

Similar correlational analyses were used to test the seventh experimental hypothesis (that improvement in drinking behavior will be related to rates of complementarity during sessions). Because the analysis using all 24 dyads would be confounded by the strong relationship between

the number of sessions attended and the rate of complementarity during the initial session and the strong relationship between the number of sessions attended and drinking outcome (to be described later in this section of the thesis), this analysis was based on the 13 treatment cases that continued through the middle and final sessions. The correlation between the sum of the Complementarity Indices across sessions and improvement in drinking behavior according to counselor ratings on the Rogers and Dymond Outcome Evaluation Form was R = .53679 with a corresponding t value with 12 degrees of freedom of 2.11 ($p < .0293$ based on a one-tailed test). The correlation between the sum of the Complementarity Indices across sessions and improvement in drinking behavior according to pre- and post-treatment differences in client ratings on the Khavari Alcohol Test was R = 0.04 with a corresponding t value with 12 degrees of freedom of 0.0088 ($p < .4484$ based on a one-tailed test). Clients in counselor-client dyads with higher rates of complementarity through six treatment sessions tended to have better drinking outcomes in the expressed judgement of counselors but not in the expressed judgements of the clients themselves.

Client Interpersonal Behavior During Sessions and Outcome

The rate of client hostile submissive behavior in initial sessions was positively and significantly related to the number of sessions attended ($n = 24$, R = .70799, t with 23 degrees of freedom = 4.702, $p < .0001$ based on a one-tailed test). In addition, the rate of submissive behavior in general (both hostile and affiliative) by clients during initial sessions was positively and significantly related to the number

of sessions attended (n = 24, R = .64875, t with 23 degrees of freedom = 3.998, p < .0006 based on a one-tailed test). In similar fashion, the rate of dominant behavior in general by clients during initial sessions was negatively and significantly related to the number of sessions attended (n = 24, R = -.43251, t with 23 degrees of freedom = 2.2488, p < .0174 based on a one-tailed test).

In order to test the sixth and eighth experimental hypotheses, only those 13 treatment cases in which clients attended through the middle and final sessions were evaluated because the comparisons involve behavioral changes from session to session.

The sixth experimental hypothesis (that the range of alcohol abusers' interpersonal operations during treatment will be related to improvement in general adjustment) was examined via correlational analyses for both changes in general adjustment according to the judgement of the counselor and according to the judgement of the client. The range of client interpersonal behavior was positively and significantly related to an increase in general adjustment according to counselor ratings on the Rogers and Dymond Outcome Evaluation Form (n = 13, R = .62138, t with 12 degrees of freedom = 2.530, p < .0117 based on a one-tailed test). On the other hand, the range of client interpersonal behavior was positively but not significantly related to an increase in general adjustment according to the difference between pre- and post treatment ratings on the Current Adjustment Rating Scale (n = 13, R = .21886, t with 12 degrees of freedom = 0.7439, p < .23625 based on a one-tailed test).

One further finding in regard to the range of client interpersonal behavior during treatment is that clients who demonstrated a greater

range of interpersonal operations during treatment tended to report more positive general adjustment prior to treatment according to pre-treatment ratings on the Current Adjustment Rating Scale ($n = 13$, $R = .49741$, t with 12 degrees of freedom = 1.9015, $p < .04185$ based on a one-tailed test).

The eighth experimental hypothesis (that the change in alcohol abusers' interpersonal operations during treatment will be related to improvement in general adjustment) was examined in similar fashion. These correlational analyses did not provide significant results. The correlation between the change in client interpersonal behavior and the difference between client pre- and post-treatment ratings on the Current Adjustment Rating Scale was $R = .13691$ ($n = 13$, t with 12 degrees of freedom = 0.45837, $p < .3278$ based on a one-tailed test). The correlation between the change in client interpersonal behavior and counselor ratings on the Rogers and Dymond Outcome Evaluation Form was $R = .35463$ ($n = 13$, t with 12 degrees of freedom = 1.258, $p < .11725$ based on a one-tailed test).

Counselor Interpersonal Behavior During Sessions and Outcome

The results of this research strongly suggest that within the treatment cases examined, counselor interpersonal behavior was not as powerful a variable in determining the outcome of treatment when compared to the impact of client interpersonal behavior.

The rate of hostile dominant behavior by counselors in initial sessions was not significantly related to the number of sessions attended by the client ($n = 24$, $R = .15598$, t with 23 degrees of freedom = 0.7407, $p < .2334$ based on a one-tailed test).

In treatment cases in which the client continued to attend through the middle and final sessions, the range of counselor interpersonal behavior was not significantly related to an increase in general adjustment either according to counselor ratings on the Rogers and Dymond Outcome Evaluation Form (n = 13, R = .14632, t with 12 degrees of freedom = 0.4906, $p < .3167$ based on a one-tailed test) or according to differences in client pre- and post-treatment ratings on the Current Adjustment Rating Scale (n = 13, R = .06184, t with 12 degrees of freedom = 0.27236, $p < .3952$ based on a one-tailed test).

Similarly, change in counselor interpersonal operations through treatment in cases in which the client attended through the middle and final sessions was not significantly related to an increase in general adjustment according to counselor ratings on the Rogers and Dymond Outcome Evaluation Form (n = 13, R = .45570, t with 12 degrees of freedom = 1.6979, $p < .0588$ based on a one-tailed test) or according to differences in client pre- and post-treatment ratings on the Current Adjustment Rating Scale (n = 13, R = .18196, t with 12 degrees of freedom = 0.6138, $p < .27595$ based on a one-tailed test). It should be noted that the relationship between change in counselor behavior and counselor rating of treatment outcome is strong but not significant.

The fourth experimental hypothesis (that the rate of affiliative dominant behavior by counselors in treatment sessions will be related to the increase in general adjustment by the client) was tested by correlating the rate of affiliative dominant behavior by counselors across sessions in treatment cases in which clients attended through the middle and final sessions with counselor ratings of treatment outcome on the Rogers and Dymond Outcome Evaluation Form (n = 13, R = .23385, t with

12 degrees of freedom = 0.7977, p <.22095 based on a one-tailed test) and with the difference between client pre- and post-treatment ratings on the Current Adjustment Rating Scale (n = 13, R = .14115, t with 12 degrees of freedom = 0.4725, p< .3228 based on a one-tailed test). Neither of these analyses revealed significant effects.

The fifth experimental hypothesis (that the rate of dominant behavior, both hostile and affiliative, by counselors in treatment sessions will be related to a decrease in drinking) was tested by correlating the rate of dominant behavior by counselors across sessions in treatment cases in which clients attended through the middle and final sessions with counselor ratings of drinking outcome on the Rogers and Dymond Outcome Evaluation Form (n = 13, R = .00710, t with 12 degrees of freedom = 0.0236, p< .4908 based on a one-tailed test) and with the difference between client pre- and post-treatment ratings on the Khavari Alcohol Test (n = 13, R = .04004, t with 12 degrees of freedom = 0.1328, p< .4484 based on a one-tailed test). Neither of these analyses revealed significant effects.

Outcome Measures

The ninth experimental hypothesis (that indicators of improvement in client drinking behavior will be related to indicators of improvement in client general adjustment) was tested via a series of correlational analyses. Increases in the difference between client pre- and post-treatment ratings on the Khavari Alcohol Test were positively but not significantly related to both increases in the difference between client pre- and post-treatment ratings on the Current Adjustment Rating Scale (n = 24, R = .31674, t with 23 degrees of freedom = 1.5662, p< .0658

based on a one-tailed test) and counselor ratings of treatment outcome on the Rogers and Dymond Outcome Evaluation Form (n = 24, R = .19490, t with 23 degrees of freedom = 0.9320, p < .1807 based on a one-tailed test). Counselor ratings of drinking outcome on the Rogers and Dymond Outcome Evaluation Form were positively and significantly related to both increases in the difference between client pre- and post-treatment ratings on the Current Adjustment Rating Scale (n = 24, R = .50561, t with 23 degrees of freedom = 2.7499, p < .00585 based on a one-tailed test) and counselor ratings of treatment outcome on the Rogers and Dymond Outcome Evaluation Form (n = 24, R = .70444, t with 23 degrees of freedom = 4.6551, p < .00005 based on a one-tailed test). These results indicate that, according to counselor ratings, improvement in drinking behavior was related to improvement in general adjustment according to both counselor and client ratings. At the same time, these relationships were not found for client ratings of improvement in drinking behavior.

In order to see if counselors and clients were making similar judgements regarding improvement in general adjustment and improvement in drinking behavior, counselor and client ratings on these dimensions were correlated. Counselor ratings of treatment outcome on the Rogers and Dymond Outcome Evaluation Form were positively and significantly related to differences in client pre- and post-treatment ratings on the Current Adjustment Rating Scale (n = 24, R = .45161, t with 23 degrees of freedom = 2.3742, p < .01335 based on a one-tailed test). Counselor ratings of improvement in drinking behavior on the Rogers and Dymond Outcome Evaluation Form were positively and significantly related to increases in the difference between client pre- and post-treatment

ratings on the Khavari Alcohol Test (n = 24, R = .69791, t with 23 degrees of freedom = 4.5706, p < .00005 based on a one-tailed test). The findings from these analyses indicate that clients and counselors were making similar judgements regarding treatment outcome in terms of both improvement in drinking behavior and improvement in general adjustment.

One powerful finding in this research that was alluded to earlier in this section of the thesis is the relationship between length of treatment and outcome. All four of the indicators of treatment outcome were positively and significantly related to the number of sessions that the client attended. The correlation between number of sessions attended and increases in the difference in between client pre- and post-treatment ratings on the Current Adjustment Rating Scale was R = .38191 (n = 24, t with 23 degrees of freedom = 1.9383, p < .03275 based on a one-tailed test). The correlation between number of sessions attended and counselor ratings of treatment outcome on the Rogers and Dymond Outcome Evaluation Form was R = .73397 (n = 24, t with 23 degrees of freedom = 5.0685, p < .0000 based on a one-tailed test). The correlation between number of sessions attended and increases in the difference between client pre- and post-treatment ratings on the Khavari Alcohol Test was R = .43316 (n = 24, t with 23 degrees of freedom = 2.2541, p < .01725 based on a one-tailed test). The correlation between number of sessions attended and counselor ratings of improvement in drinking behavior on the Rogers and Dymond Outcome Evaluation Form was R = .68480 (n = 24, t with 23 degrees of freedom = 4.4079, p < .0001 based on a one-tailed test). Length of treatment was strongly related to improvement in both drinking behavior and general adjustment

There is evidence to suggest that this effect occurs throughout levels of severity of the initial problem. Number of sessions attended was not significantly related to client pre-treatment ratings on the Current Adjustment Rating Scale ($n = 24$, $R = .11403$, t with 23 degrees of freedom = 0.5383, $p < .5957$ based on a two-tailed test) or client pre-treatment ratings on the Khavari Alcohol Test ($n = 24$, $R = .22098$, t with 23 degrees of freedom = 1.0625, $p < .2994$ based on a two-tailed test). These results suggest that severity of the presenting problem, either in terms of alcohol consumption or in terms of general adjustment, did not tend to alter the length of treatment.

CHAPTER V

DISCUSSION

The results of this project support the following specific conclusions in light of the general hypotheses based on the therapist-client dyads examined in this research.

1. In initial interactions with therapists in treatment, alcohol abusers tended to present primarily hostile dependent interpersonal operations.

2. In initial interactions with alcohol abusers in treatment, therapists tended to present primarily hostile dominant interpersonal operations.

3. Therapist-client dyads in alcohol abuse treatment with higher rates of complementarity in the initial phase of treatment tended to have higher attendance than therapist-client dyads with lower rates of interpersonal complementarity in the initial phase of treatment.

4. In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, alcohol abusers interacting with therapists demonstrating more affiliative dominant behaviors did not tend to show more improvement in general adjustment than alcohol abusers interacting with therapists demonstrating less affiliative dominant behaviors.

5. In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, alcohol abusers interacting with therapists demonstrating more dominant behaviors did not tend to show more improvement in drinking behavior than alcohol abusers interacting with therapists demonstrating less dominant behaviors.

6. In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, alcohol abusers demonstrating more rigid interpersonal behavior during treatment tended to show less improvement according to therapist ratings in general adjustment than alcohol abusers demonstrating more flexible interpersonal behavior during treatment. This effect was not found according to client ratings.

7. In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, alcohol abusers in dyads with higher rates of interpersonal complementarity demonstrated greater improvement in drinking behavior in the expressed judgement of therapists. This effect was not found according to client ratings.

8. In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, alcohol abusers who demonstrated greater changes in interpersonal operations within treatment interactions did not show greater improvement in general adjustment according to both client and therapist ratings.

9. Client improvement in drinking behavior according to the judgement of clients was positively but not significantly related to both client and therapist ratings of client improvement in general adjustment. Client improvement in drinking behavior according to the judgement of therapists was positively and significantly related to both client and therapist ratings of client improvement in general adjustment.

The results of this project support the following additional conclusions.

1. In terms of the variables assessed within this research project, alcohol abusers who entered treatment on a voluntary basis did not tend to behave differently within treatment nor did they tend to demonstrate different responses to treatment when compared to alcohol abusers who entered treatment on the basis of an order from the court.

2. As treatment progressed through the initial, middle, and final phases, therapists tended to maintain a rigid interpersonal presentation based on hostile dominant operations. Alcohol abusers in treatment, on the other hand, tended to become more flexible in their interpersonal operations as treatment progressed.

3. In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, the rate of interpersonal complementarity tended to be highest in the initial phase of treatment then decrease and continue at a stable rate through the middle and final phases.

4. Clients who demonstrated greater rates of both hostile submissive behavior and submissive behavior in general in the initial phase of treatment were more likely to stay in treatment longer.

5 In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, alcohol abusers who reported more positive general adjustment prior to treatment tended to demonstrate a greater range of interpersonal operations within treatment when compared with alcohol abusers who reported less positive general adjustment prior to treatment

6 Therapists who demonstrated a greater rate of hostile dominant behavior in the initial phase of treatment were not more likely to be involved in treatments that lasted longer than therapists who demonstrated a lower rate of hostile dominant behavior in the initial phase of treatment.

7 In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, the range of therapist interpersonal behavior was not related to therapist ratings or client ratings of increases in general adjustment.

8 In therapist-client dyads in which the client continued to attend beyond the initial phase of treatment, therapists who demonstrated greater changes in interpersonal operations during treatment did not tend to be involved with clients who demonstrated greater increases in general adjustment when compared with therapists who demonstrated less changes in interpersonal operations during treatment.

9 Therapists and clients tended to make similar judgements regarding treatment outcome in terms of both improvement in drinking behavior and improvement in general adjustment

10 Regardless of the severity of the presenting problem either in terms of drinking behavior or general adjustment, the length of treatment was positively related to treatment outcome according to all four measures of outcome used in this research: therapist ratings of improvement in drinking behavior, therapist ratings of improvement in general adjustment, client ratings of improvement in drinking behavior, and client ratings of improvement in general adjustment

The findings of this research project are in strong support of the notion that an understanding of the interpersonal dynamics of the treatment of alcohol abuse can be integral to such intervantions.

Client Interpersonal Behavior in Treatment

Clients tended to present interpersonal behaviors, particularly in the initial phase of treatment, that are highly coincident with the personality characteristics of alcohol abusers supported by research and theory reviewed in a previous section of this thesis. These hostile and submissive qualities suggest that alcohol abusers do suffer from dependency conflicts which they tend to bring to treatment. Further, as anticipated on the basis of the models of interpersonal reciprocity, clients tended to elicit complementary interpersonal reflexes from therapists. These kinds of reflex behaviors exhibited by therapists encountering alcohol abusers in treatment suggest that they are responding on the basis of issues surrounding dependency in clients.

Clients who presented greater rates of hostile submissive behavior tended to stay in treatment longer. This finding suggests that the more comfortable and expressive the alcohol abuser is with these behaviors, the more likely it is that he or she will stay in treatment and, consequently, benefit from treatment. In this sense, the task of the therapist in the initial phase of treatment is to create an environment in which the client is most likely to behave in hostile submissive ways.

Clients tended to modify their interpersonal behavior as treatment progressed. This finding suggests that alcohol abusers in treatment as a group, regardless of treatment outcome, tend to behave in less rigid ways as treatment proceeds.

Counselor Interpersonal Behavior in Treatment

The predictions of counselor interpersonal behavior based on both the models of interpersonal reciprocity and the research on the expressed

attitudes of alcohol treatment personnel were confirmed. Therapists tended to present primarily hostile dominant behavior throughout all phases of treatment reviewed. They were more rigid in their interpersonal presentation than clients. This raises a variety of issues.

One issue that this finding raises is the possibility that therapists do not modify their interpersonal presentation until later in treatment. Perhaps the behavior exhibited by therapists in the first six sessions, as examined in this research, is part of an incubation period in which clients experiment with their behavior but therapists do not. This possibility concurs with the analysis of the treatment of dependent clients originally proposed by Snyder (1963) and supported by later research. Within this analysis, the purpose of the therapist is to meet the dependency needs of the clients, particularly in the initial phase of treatment, in order to build a stable therapeutic relationship. The therapist can eventually relinquish a more directive orientation when the client no longer requires this kind of security.

A second possibility raised by the finding that therapists continue to present predominantly hostile dominant operations is that they are not being responsive to the changes in interpersonal behavior presented by clients. In terms of interpersonal reciprocity, they may be behaving in a manner that contributes to the creation of an unstable treatment relationship that is not based on complementary and spontaneous interpersonal exchange.

This possibility has been addressed by Sterne and Pittman (1965) who referred to the overemphasis of the 'motivational problem' as an expression of resistance in treatment personnel. In similar fashion, Mogar, Helm, Snedeker, Snedeker, and Wilson (1969) and Reinehr (1969)

have presented the notion that alcohol treatment personnel present dispositions toward alcohol abusers that are fundamentally rigid and negative. This analysis suggests that the rigid way in which therapists respond to alcohol abusers in treatment may be more a function of a general attitude than specific to the client at hand. Therapists may be reinforcing hostile submission in clients rather than treating it. The test of whether the client can benefit from treatment may lie in his or her ability to benefit and grow in a hostile dominant environment.

The finding that the range of counselor interpersonal behavior and the change in counselor interpersonal behavior did not have a significant overall effect on treatment outcome further supports the possibility that counselors were not responding to client changes in interpersonal behavior. What may have been witnessed is the lack of interpersonal flexibility in counselors rather than the effect of interpersonal flexibility in counselors.

There is evidence to suggest that alcohol treatment personnel are not aware of their rigidly hostile dominant presentation. Both Morgan et al. and Sterne and Pittman referred to an "unconscious conflict" in treatment personnel. In addition, Ansel (1981) found that counselors in alcohol treatment report that they tend to present primarily affiliative dominant behaviors in treatment. That finding is based on the same dimensions as were used in the current research.

The Dynamic Interplay Between Clients and Counselors

The results of this research support the viability of conceptualizing the process of alcohol treatment in terms of the interpersonal dynamics of the relationship between client and therapist. In a previous

section of this thesis the position of McLemore and Benjamin (1979) was presented that clinical diagnostic information could be presented in terms of interpersonal behavior. In conjunction with other authors, McLemore and Benjamin proposed that the more flexible an individual is, the more psychologically 'healthy' the individual is. A powerful finding of the current research in this regard is that clients who reported more favorable general adjustment prior to treatment tended to display a greater range of interpersonal operations during treatment.

On the basis of the original position presented by Sullivan (1965) regarding the "complementary" and 'antagonistic" qualities of human interactions, Benjamin (1974) identified 'complaments' and 'antidotes" for patients' behavior in treatment. As mentioned previously, alcohol counselors tended to present"complements" to hostile submissive behavior in clients but did not tend to present "antidotes' (i.e., affiliative dominant behavior). Further, the rate of affiliative dominant behavior in therapists did not tend to have a significant impact on the outcome of treatment. These findings may not be conclusive, however, due to the limited amount of affiliative dominant behavior displayed by therapists within this research.

It appears that alcohol abusers and counselors in treatment tend to be involved in a highly complementary interpersonal system in the initial phase of treatment but that the level of complementary tends decrease as treatment progresses. This finding concurs with the research on complementarity presented by Dietzel and Abeles (1975). Within the present research, it appears that the decrease in this rate is due almost exclusively to a change in interpersonal presentation by clients. It should be noted that Dietzel and Abeles found that the rate of comple-

mentarity tended to increase following the middle phase of treatment. That research, however, was based on an analysis of nine treatment sessions, the current findings are based on an analysis of six sessions. Consequently, the middle phase of the research presented by Dietzel and Abeles corresponds roughly with the final stage of the current research. It is possible that the level of complementarity could increase following the sixth session.

The decrease in complementarity may indicate that the participants in treatment are beginning to engage in a more meaningful interpersonal exchange. The initial phase of treatment can be described as a rigidly defined interaction providing for little behavioral experimentation. As complementarity decreases, clients and therapists can begin to interact in a more complex and flexible manner. This analysis concurs with the conception of the dynamic development of psychotherapeutic interventions proposed by Crowder (1972).

The finding that higher rates of complementarity in the initial phase of treatment was associated with an increase in the length of treatment supports the notion that therapeutic responsivity to the hostile and submissive qualities of alcohol abusers is endemic to treatment success. This is particularly important to note in light of the strong relationship between length of treatment and treatment outcome.

There is also evidence in the findings of the current research that higher rates of interpersonal complementarity are associated with greater improvement in drinking behavior. It may be the case that a comfortable and stable interchange between the therapist and the client makes it more likely that the client will modify his or her drinking behavior

In terms of the interpersonal behavior displayed by clients, there is evidence to suggest that alcohol abusers who demonstrate more flexible interpersonal behavior during treatment may show more improvement in general adjustment as a function of treatment. There are mixed findings in this regard within the current research, however, as this effect was only found relative to therapists' ratings of improvement. Further, the rate of change in client interpersonal operations within treatment was not associated with greater improvement in general adjustment. In summery, it appears that client experimentation with interpersonal behaviors did not show a direct relationship with improvement in general adjustment. Therapist experimentation with interpersonal behavior in terms of the range of behavior as well as the rate of change of behavior also did not show a direct relationship with client improvement in general adjustment. These findings do not support the notion that strategic manipulation of the dynamic interplay between clients and therapists in alcohol treatment will foster treatment outcome within the first six sessions.

It appears that the therapists in this research are responding to the initial presentation of clients in alcohol treatment but that they are not responding to the subtle changes in interpersonal behavior by clients as treatment proceeds. According to the theory and research reviewed in a previous section of this thesis regarding therapeutic responsivity to dependency and hostility in clients, therapists are responding to the problem but not to the solution. That is, by virtue of their interpersonal behavior, therapists are providing an environment in which clients are likely to behave in hostile and submissive ways but not likely to change this kind of presentation. On the other hand, it

eppears that therapists are meeting the dependency needs of alcohol abusers in treatment which may allow clients to feel secure enough to experiment with their interpersonal behavior.

One problem with the rigidly hostile dominant interpersonal behavior by alcohol counselors is that the effect of treatment may be short-lived. When the support of the presence of e therepist is removed and the dependency needs are no longer met, the client may return to e previous level of functioning. The literature reviewed in a previous section of this thesis regarding the dynamic development of psychotherapeutic treatment supported the position that a distinction should be made between the potentiel short-term benefits of complementary behavior by therapists and the potential long-term benefits. If alcohol counselors continue to present predominantly hostile dominent operetions in treatment, clients may not gain the opportunity to develop e wider range of coping mechanisms in terms of interpersonal behavior.

One additional finding in light of therapist interpersonal behavior is thet the rate of dominant behavior by alcohol counselors was not essociated with client improvement in drinking behavior. This finding was not anticipeted. Previous research has supported the position thet more directive approaches ere more effective than less directive approaches in the treatment of alcohol abuse. It is possible that the therepist behevior included in the current reseerch did not provide enough variability elong this dimension to accurately test this hypothesis. As mentioned previously, alcohol counselors as a group presented primerily hostile dominant behavior throughout all six sessions examined. Most of the previous reseerch supporting this position was based on systematicelly comparing different schools of psychotherapy.

Treatment Outcome

The most powerful finding in regard to the measures of treatment outcome is the strong relationship between length of treatment and all four measures of treatment outcome. The longer treatment lasted the more likely it was the clients demonstrated improvement in both drinking behavior and general adjustment. This finding provides further support for the contention that length of treatment is a viable outcome measure in research on the treatment of alcohol abuse. It is simple and direct but appears to have as much or more value than more sophisticated measures in assessing treatment outcome.

Pattison, Sobell, and Sobell (1977) have reviewed the literature on the relationship between drinking behavior and general adjustment. In their review of research on outcome of treatment of alcohol abuse, they concluded that there is a positive but not necessary relationship between improvement in drinking behavior and improvement in other areas. The findings of the current research support this position. Client assessment of drinking outcome was positively but not significantly associated with ratings of improvement in general adjustment. There was a positive and significant relationship between counselor assessment of drinking outcome and ratings of improvement in general adjustment. One conclusion to be gained from these findings is that sole reliance on drinking outcome may not do justice to the evaluation of the treatment of alcohol abuse. Other changes can be occurring that may eventually enable the alcohol abuser to suffer less from the effects of drinking and have a more favorable adjustment in other areas of functioning.

An encouraging finding in light of the validity of the measures used to assess outcome in the current research is that therapist judgements and client judgements in terms of both drinking outcome and improvement in general adjustment were positively related. This finding supports the position presented by Armor, Polich, and Stambul (1978) that alcohol abusers can and do accurately report their drinking behavior.

Final Considerations

It should be noted that subject selection may have had an impact on the findings presented in this thesis. In a review of literature of patient retention in outpatient alcoholism treatment, Rosenberg, Gerrein, Manohar, and Liftik (1976) concluded that up to 60% of patients fail to return for a second visit and less than 25% remain for more than four visits. Using these figures as a baseline, it may be the case that the clients who participated in the current research were either more motivated for treatment or adapted their approach to treatment once they were included in the project. Another possible bias in terms of subject selection was referred to by Garfield (1978) in a review of studies of patients in general psychotherapy who complete pre-therapy questionnaires. The author concluded that patients who consent to participate in these kinds of studies are more likely to continue treatment. An implication of this conclusion is tht alcohol abusers who were more difficult to retain in treatment may not have participated in the study.

Another limitation of the current research is the short-term nature of the assessment of outcome. It may take more than six treatment sessions to see the full impact of the dynamic interplay between alcohol

abusers and therapists in treatment. Further, it is possible that the benefits of treatment within the first six sessions may be short-lived. It has been well-documented in the field of Social Psychology that monitored subjects tend to increase performance regardless of the experimental manipulations applied.

The experimental model applied for the current research, if extended across more treatment sessions, would be able to assess several issues that were not resolved in this thesis. First, therapist interpersonal behavior in response to the increasing variability of client interpersonal behavior could be assessed. Second, the stability of client changes in interpersonal behavior as well as drinking behavior beyond the first six sessions could be evaluated. Third, client responses to changes in therapist interpersonal behavior could be assessed, that is, how clients behave in treatment and in their drinking and general adjustment when the security of a hostile dominant therapist is removed.

A finding that adds credibility to the conclusions of this thesis is that the findings generalize across voluntary and committed clients. The problem of client "drop out" appears to be similar for both groups. In addition, both groups of clients tended to display similar interpersonal behaviors in treatment and similar responses to treatment.

General Conclusions

This research supports the position that alcohol abusers and counselors in treatment tend to participate in a rigidly defined and complementary interpersonal situation in initial interviews. Counselors tend to maintain this initially rigid presentation but clients tend to

alter their interpersonal operations. The changes in client interpersonal behavior did not, however, have a significant effect on treatment outcome.

The rate of client hostile submissive behavior in initial interviews and the rate of complementarity in initial interviews were positively related to the length of treatment. The length of treatment was positively related to all measures of treatment outcome. A conclusion is that clients in treatment for alcohol abuse who are received in an environment that encourages the free expression of hostile submissive qualities are more likely to benefit from treatment.

There was a positive but not necessary relationship between client improvement in drinking behavior and client improvement in general adjustment. When compared with therapists' judgements, clients accurately reported the extent of their alcohol consumption.

The current research has meaning in terms of a controversy in the alcohol treatment field that has had a powerful impact in the last fifteen years. This controversy has affected the field politically as well as empirically. Following publication of a series of studies by Pattison, Sobell, and Sobell (1977) supporting the position that there is no absolute relationship between drinking outcome and treatment outcome in other areas, many treatment professionals took objection to this position. The thrust of this counter-position is that in order to treat the alcoholic the drinking problem must be ameliorated. That is, until the abuser stops drinking or improves in his or her drinking behavior treatment cannot take place.

This controversy has manifested itself in issues surrounding assessment of treatment outcome. For example, some authors who have

accepted the latter position have argued that abstinence is the only viable treatment outcome. Others who have accepted the position presented by Pattison, Sobell, and Sobell (1977), have argued that control of the drinking problem is also a viable treatment outcome. These kinds of issues have had a pronounced impact on funding treatment programs as well as on orchestration and conceptualization of individual treatment cases.

The findings of the current research are consonant with the position advocated by Pattison, Sobell, and Sobell (1977). There was a positive but not necessary relationship between drinking outcome and changes in general adjustment. Further, it was clear that although few of the subjects in the study actually stopped drinking in conjunction with treatment, there was a general tendency for subjects to alter their drinking pattern.

An additional implication of the current research is that training for alcohol counselors should be designed to prepare them to provide the kind of environment in therapy for alcohol abusers to be able to freely exhibit hostile submissive behavior. Further, training could also be designed to assist counselors in strategically approaching and manipulating issues clients have in terms of hostility and dependency.

APPENDIX A

INFORMED CONSENT FOR
ALCOHOL COUNSELORS

As per the oral presentation that was made previously, you are being asked to participate in my dissertation research on the treatment of alcohol abuse. As you may be well aware is the case in this kind of research, all of the information that is collected will be strictly confidential to the fullest extent provided by law and, barring any legal action, will be used only for the purposes of this study. You are certainly free to choose not to participate in the research, and, should you choose to participate, you are free to discontinue at any time without prejudice. Whether or not you choose to participate in this study should not have any bearing on your status as a counselor or on how your supervisors evaluate your work.

The explicit purposes of this study will not be available to you until all of the data have been collected. The experimental hypotheses, the results, and the implications of the results will be provided in written form upon completion of the study. Hopefully, the findings will have some positive impact on future treatment interventions you will make.

Each client that you see in individual counseling will be asked to participate in the study. For clients who consent to participate, you will be asked to audiotape each interview, including the first through the sixth sessions. Tapes and tape recorders will be provided. The consenting clients will be completing forms pertaining to their general adjustment and to their drinking patterns prior to and following counseling with you. You will be asked to evaluate the effects of counseling for each client on a questionnaire with five Likert-type items following cessation of counseling or following the sixth interview, whichever comes first. In addition, you will be asked to label each audiotape with the date, identification of the client, and the particular session that is on that tape.

The research materials will be labeled with numbers for both clients and counselors in order to minimize the possibility that the research participants can be identified. Further, the individuals who score the audiotapes will be unfamiliar with you as counselors and will have no influence in terms of evaluating the quality of the treatment rendered during the counseling sessions.

The principal investigator is available to answer any inquiries you might have concerning the procedures. No monetary compensation is offered, however, your participation is genuinely appreciated.

I have read and I understand the procedure described above. I agree to participate in the procedure and I have received a copy of this description.

Subject _____ Date _____

Witness _____ Date _____

James C. Ansel
Department of Clinical Services
St. Mary of the Angels Home
Convent Road
Syosset, New York 11791
(516) 678 6916

APPENDIX B

COVER SHEET FOR DATA COLLECTION

1. Counselor number _____

2. Client number _____
(Please make sure this number can be matched with the name of the client.)

3. Age of client _____

4. Sex of client _____

5. Indicate whether or not this client was required to attend counseling by the court _____Yes _____No

6. List the dates which you have interviewed this client including the intake. Please indicate any of the sessions which were not audio-taped.

Reminders:

1. Please let either the receptionists or myself know as soon as a sixth interview with this client has been completed or as soon as you are reasonably sure that the client's treatment has been discontinued so that follow-up measures can be initiated. As much as possible, this should be done while the client is still at the clinic. It is important that clients who are only seen once for treatment are included.

2. Make sure that all audiotapes are labelled with your number, client number, date of the interview, and the sequence of the interview.

3. Complete the Rogers Outcome Evaluation Form following the sixth interview with the client or following cessation of treatment.

4. Return all of the materials including this form, the Rogers Evaluation form, and the audiotapes to the receptionists or myself.

Your participation is appreciated.

James Ansel
Principal Investigator

APPENDIX C

CONSENT FORM FOR CLIENTS
CONSENT FOR RESEARCH

In order that we can develop the procedures and techniques that are used in treatment, we would like you to participate in a research study. We would like you to fill out some questionnaires before your counseling begins and then again after you have met with your counselor for a number of sessions. In addition, we would like to make audiotapes of your counseling sessions so that we can study them.

You are free to choose not to participate in this study, and if you do choose to participate, you are free to discontinue at any time. Whether or not you choose to participate in this study will have no bearing on who your counselor will be or on the kind of treatment you receive. All information that will be collected is strictly confidential to the fullest degree provided by legal and professional standards.

In exchange for your participation in the study a 15 dollar check will be mailed to you following receipt of the final questionnaires.

The members of the mental health center staff (including your counselor) are available to answer any questions that you have.

I have read and I understand the procedure described above. I agree to participate in the procedure and I have received a copy of this description.

Subject _____ Date _____

Witness _____ Date _____

James C. Ansel
Department of Clinical Services
St. Mary of the Angels Home
Convent Road
Syosset, New York 11791

APPENDIX D

PRE-TREATMENT
CURRENT ADJUSTMENT RATING SCALE

Name_____

Age_____

Sex_____

Date _____

Name and Location of Treatment Facility_____

_____

Rate yourself on the following questions by placing a ( ) check mark in the appropriate place along the scale. Be sure to answer all of the questions. If you are unsure of your answer, make your best guess.

1. Overall estimate of your current functioning.

Severely disturbed functioning				Moderately disturbed functioning				Mildly impaired functioning	

2. Your current work adjustment:

Very unhappy and unproductive								Very happy and productive	

3. Current relationships with friends and relatives

Very unsatisfying for him								Very satisfying for him	

4. Current relationship with husband or wife (if not married, to closest opposite-sexed friend).

Very unsatisfying for him								Very satisfying for him	

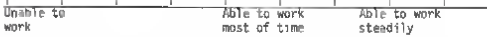
5. Adequacy of current life adjustment.

6 Your current "likeability" how likeable are you to others as a person

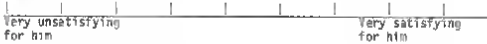
7 To what extent are you living up to your potential in your work?

8. To what extent are you living up to your potential as a person?

9 Occupational adjustment



10. Sexual adjustment.



11. Current leisure time activity.

12. Current relationships with friends

APPENDIX E

INSTRUCTIONS FOR
POST-TREATMENT QUESTIONNAIRES

These scales are designed for you to evaluate the effects of your current counseling. Answer the following questions according to your life experiences since you have entered counseling with this counselor.

APPENDIX F

POST-TREATMENT

CURRENT ADJUSTMENT RATING SCALE

Name_____

Age_____

Sex_____

Date_____

Name and Location of Treatment Facility_____

_____

Rate yourself on the following questions by placing a ( ) check mark in the appropriate place along the scales. Be sure to answer all of the questions. If you are unsure of your answer, make your best guess.

1. Overall estimate of your current functioning.

Severely disturbed functioning					Moderately disturbed functioning					Mildly impaired functioning

2. Your current work adjustment.

Very unhappy and unproductive										Very happy and productive

3. Current relationships with friends and relatives

Very unsatisfying for him										Very satisfying for him

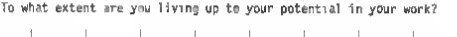
4. Current relationship with husband or wife (if not married, to closest opposite-sexed friend)

Very unsatisfying for him										Very satisfying for him

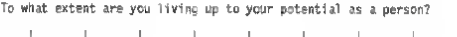
5. Adequacy of current life adjustment

6. Your current "likeability": how likeable are you to others as a person

7. To what extent are you living up to your potential in your work?



8. To what extent are you living up to your potential as a person?



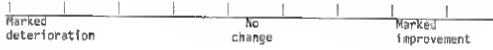
9. Occupational adjustment

10. Sexual adjustment

11. Current leisure time activity

12. Current relationships with friends

13. Change since you first entered treatment with your current counselor



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BIOGRAPHICAL SKETCH

The author was born and raised in a rural community in Lancaster County, Pennsylvania. After graduation from the Pennsylvania Public School System in 1972, he attended Bucknell University from 1972 to 1976 where he received varsity letters in soccer and baseball. In June, 1976, he graduated cum laude in psychology.

In September, 1976, the author received an appointment as a research assistant and instructor in social psychology at his alma mater. In September, 1977, he was admitted into the doctoral program in counseling psychology at the University of Florida. During his tenure there, the author was instrumental in developing and administrating a treatment program for alcohol and substance abuse for students and staff. This program is housed in the University Vocational and Psychological Counseling Center.

The author was married to Esther Sauder-Ansel in September, 1980. He and his wife moved to Norfolk, Nebraska, in August, 1981, where he served his internship in clinical and community psychology at the Northern Nebraska Comprehensive Mental Health Center. The couple moved to New York City in September, 1983, so that Esther could begin graduate training in the doctoral program in clinical psychology at Long Island University. The author is currently employed as a clinical psychologist working with juvenile delinquents at Saint Mary of the Angels Home in Syosset, New York.

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Harry Grater, Chairman
Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

David Suchman
Associate Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Gerardo Gonzalez
Assistant Professor of Counselor Education

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy.

Dorothy Nevill
Associate Professor of Psychology

I certify that I have read this study and that in my opinion it conforms to acceptable standards of scholarly presentation and is fully adequate, in scope and quality, as a dissertation for the degree of Doctor of Philosophy

Robert Zitter
Professor of Psychology

This dissertation was submitted to the Graduate Faculty of the Department of Psychology in the College of Liberal Arts and Sciences and to the Graduate School, and was accepted as partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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Dean for Graduate Studies and Research